Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2014	2014_378116_0004	T-102-14	Resident Quality Inspection

Licensee/Titulaire de permis

UNIONVILLE HOME SOCIETY
4300 Highway #7, MARKHAM, ON, L3R-1L8

Long-Term Care Home/Foyer de soins de longue durée

UNION VILLA
4300 Highway #7, Unionville, ON, L3R-1L8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SARAN DANIEL-DODD (116), JULIENNE NGONLOGA (502), SOFIA DASILVA (567)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 5, 6, 9, 10, 11, 12,13,16, 17, 18, 19, 2014.

Log #497-14 (Follow up to orders issued under Log #729-13 inspection# 2014_102116_0012) was conducted in conjunction with this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer/Administrator, Acting Director of Long Term Care Operations, Acting Director of Nursing and Personal Care, Education Coordinator, Human Resources Manager, Food Service Manager, Environmental Manager, (resident assessment instrument-minimum data set)RAI-MDS coordinator, nurse managers, registered dietitian, pharmacist, registered staff, personal support workers(PSW), physiotherapist, housekeepers, environmental staff, maintenance technicians, activity programmers, social workers, dietary staff, Resident Council president, Family Council president, residents, families and visitors.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed meal service, resident care, staff-resident interactions and medication administration. Reviewed relevant home records, relevant policy and procedures, training records, employee records and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A review of resident #255's health record indicated that the resident requires assistance with toileting and uses a specific altered feeding method.

Resident #255 reported to the inspector that on a specified date, resident #255 needed to use the washroom and called for assistance. An identified PSW responded to the call bell and informed the resident that he/she would return shortly. Resident #255 reported that he/she waited at least two hours without assistance and attempted to use the washroom on his/her own. The resident lost control of his/her bowels, soiling the floor, carpet, bed, bedding, resident's face and nails with feces. The resident stated that he/she felt awful after the incident.

Review of the home's call-bell report, titled Callpoint Detailed Activity Report, revealed that on a specified date, resident #255 called for assistance at an identified time and the call lasted 48 seconds. The resident called again at a specified time, and the call lasted 15 minutes.

Record review and interviews held with the assigned PSW and the registered staff confirmed the incident. Further, during the incident, the resident's altered feeding method came out, requiring the resident to be transferred to the hospital the next day for treatment intervention.

Interview with an identified nurse manager indicated that having a call bell ring for 15 minutes is not acceptable. [s. 3. (1) 1.]

2. Review of resident #268's health record indicated that the resident has dementia. Review of progress notes for a specified period documented comments that do not fully recognize the resident's individuality and respect the resident's dignity.

Interview held with an identified staff member confirmed being aware of the resident's health condition and that the resident is very emotional and is dependent on the identified staff member for social interaction. The identified staff member confirmed ignoring resident #268 over a specified period. The identified staff member also

confirmed that it wasn't appropriate to treat the resident in that manner.

Interviews held with the Administrator, DON, and social workers confirmed that the negative treatment towards resident #268 is not acceptable and does not uphold the resident's right to be treated with courtesy and respect. The staff member was disciplined as a result of this incident. [s. 3. (1) 1.]

3. The licensee failed to ensure that resident #268 was protected from emotional abuse.
For the purposes of definition of "abuse" in subsection 2(1) of the Act, "emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Review of resident #268's health record indicated that the resident has dementia. Review of progress notes for a specified period documented threatening, intimidating comments and acts of imposed social isolation, ignoring and restriction from social activities within the home made towards the resident by an identified staff member.

Negative comments made towards resident #268 were documented by the identified staff member within the resident's progress notes.

Interview held with the identified staff member confirmed being aware of the resident's health condition and that the resident is very emotional and is dependent on the identified staff member for social interaction. Furthermore, the staff member confirmed restricting and ignoring resident #268 over a specified period of time.

Interviews held with the Administrator, DON, and social workers confirmed that the negative treatment towards resident #268 is not acceptable and contrary to the homes zero tolerance for abuse policy. The staff member was disciplined as a result of this incident. [s. 3. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted for resident's #255 and #268:

- they are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and,
- to ensure that resident #268 is protected from emotional abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On a specified date, a clean utility room was observed to be open and accessible containing sharp razors that presents a safety hazard for cognitively impaired residents. An identified staff member confirmed that the doors to the clean utility room should be locked. [s. 5.]

2. On a specified date, during an identified meal service, the spa room door on an identified unit was observed to be open and unsupervised. The spa floor was observed to be wet, presenting a slipping hazard.

An interview with an identified manager confirmed that the spa room should be inaccessible to resident's when unsupervised. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of resident #189's plan of care confirms a diagnosis of a mental illness. Review of the resident's health record and interviews with identified staff confirm that resident #189 requires a supplement drink daily at dinner.

Interview with the food service supervisor (FSS) revealed that the resident receives a supplement pudding; the FSS also stated that the resident will not accept the supplement from staff as a result of his/her health condition. An agreed upon intervention between the FSS and the resident's Power of Attorney (POA) allows for the provision of the supplement pudding to the resident's POA who then provides it to the resident. The FSS provides the supplement one week in advance to the POA and the resident receives the supplement as required.

The written plan of care does not contain this intervention. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of resident #330's plan of care indicates that the resident needs his/her food to be cut into small pieces.

On an identified date, the inspector observed that resident #330, was served regular texture meat that was not cut in small pieces. (502)

Resident #4's written plan of care documents that the resident requires two people for physical assistance for the entire process of toileting related to unsteady gait and cognitive deficit.

On a specified date, the inspector observed an identified PSW transferring resident #4 off the toilet without the assistance of another person as per the plan of care. Interview held with the assigned PSW indicated that the resident is able to be toileted by one person. Interviews held with PSWs, registered staff and the nurse manager confirmed that resident #4 requires two persons at all times for transfers and toileting. [s. 6. (7)]

3. The licensee failed to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of resident #330's plan of care indicates that the resident needs constant encouragement and staff should remain with the resident during meals.

On a specified date, the inspector observed that staff did not provide constant

encouragement or remained with the resident during the meal as required in the plan of care.

An interview with the registered dietitian (RD) indicated that resident #330 likes to be independent and will get upset if staff sit by his/her side to provide assistance. The plan of care was not revised to reflect the resident's need to eat independently with minimal or no supervision. [s. 6. (10) (b)]

4. A review of resident #175's plan of care indicates that the resident is identified at high risk for nutrition and confirms a diagnosis of mental illness. The plan of care further indicates to provide a specified diet of regular texture, and does not include the provision to serve all meal courses at the same time.

On a specified date, during an identified meal service, the inspector observed that resident #175 was served soup, entrée, and dessert, at the same time.

An interview with the RD indicates the resident's eating habits depend on resident #175's mood. The resident prefers to be served all courses at once. The plan of care was not revised to reflect the resident's preference regarding all courses to be served at once. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care provides the following:

1. sets out clear directions to staff and others who provide direct care to the resident

2. that the care set out in the plan of care is provided to the resident as specified in the plan and,

3. that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

On a specified date, resident #255 reported to the inspector that sometime during a specified period, a direct care staff member was rough with him/her and rushed him/her during care. The resident relayed that he/she brought the concerns forward to the nurse manager who requested that the resident provide a written complaint. The resident confirmed that a written complaint was submitted to the home.

An interview with a nurse manager confirmed that the concerns were verbally communicated by him/her to his/her family, and the suspicion of rough handling was reported to the DON.

Record review and staff interview confirmed there is no written record of the home's internal investigation. As a result, the home did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are monitored during meals, including residents eating in locations other than dining areas.

On a specified date, the inspector observed lunch service in an identified dining room. The registered staff, responsible to supervise the meal service was not in the dining room at the beginning of the meal service.

Resident #10 was wandering in and out of the dining room during the meal. An identified PSW, who was assisting two residents, was interrupted while providing assistance with feeding in order to provide assistance to resident #10.

Interview with a nurse manager indicated that registered staff are expected to be in the dining room at the beginning of meal services. [s. 73. (1) 4.]

2. The licensee failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

The written plans of care for residents #8 and #9 indicate that both residents require monitoring during meals due to risk of aspiration and signs of dysphagia.

On a specified date, the inspector observed residents #8 and #9 being fed in unsafe positions during the lunch meal service in the first floor dining room. Both residents were observed to be seated at a 60-degree angle.

Interviews held with identified PSWs and a registered staff member confirmed that both residents were not positioned safely for feeding.

On the same day during the snack service, the inspector observed an identified PSW feeding resident #22 while standing in front of the resident at an arm's length distance. The resident's chin was elevated, and was forced to extend his/her neck to reach for the spoon.

The assigned PSW confirmed that the feeding position was not safe and should be sitting while providing assistance with meals. [s. 73. (1) 10.]

3. The licensee failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

The written plans of care for resident's #17, #18 and #19 indicate that they require total assistance with meals. On a specified date, the inspector observed residents

#17, #18, and #19 sitting at an identified table, being assisted by one PSW at the same time. [s. 73. (2) (a)]

4. The licensee has failed to ensure that residents who require assistance with eating or drinking were only served a meal when someone was available to provide them assistance.

The written plan of care for resident #12 documents that the resident requires extensive assistance with eating. On a specified date, the inspector observed that resident #12's meal was plated and served prior to a staff member being available to provide assistance. An identified PSW confirmed that the resident needs assistance with meals. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:
1. residents are monitored during meals, including residents eating in locations other than dining areas,
2. proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance,
3. to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking and,
4. that residents who require assistance with eating or drinking were only served a meal when someone was available to provide them assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On a specified date, the inspector observed two containers of hazardous substances left unattended in an identified dining room. Two residents were present in the dining room.

An interview with an identified maintenance technician confirmed that the chemicals were left unattended for 45 minutes.

Interviews with the environmental manager and a nurse manager confirmed that hazardous substances should not be left unattended. [s. 91.]

2. On a specified date, during a meal service, the spa room door on an identified unit was
observed to be open and unsupervised. The spa room contained the following chemicals:
Oxivir five 16 and Virox stored on the floor.

An interview with the maintenance manager confirmed that all hazardous substances should be inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all time, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy and that complies with the manufacturer’s instructions for the storage of the drugs.

On specified dates during the inspection, the inspector observed Nutrassist and Resource 2.0 sitting on top of the medication cart on an identified unit. These products require refrigeration once open, as per the manufacturer's instructions for storage.

On all occasions, interviews with registered staff confirmed that the products had been left out since the morning medication administration pass. Further, interviews with registered staff and a nurse manager confirmed that Nutrassist and Resource 2.0 should be refrigerated once opened.

On a specified date, the inspector observed that the medication refrigerator temperature was 10 degrees Celsius. Medication stored in the refrigerator included Lantus Solostar, which was required to be refrigerated between 2 and 8 degrees Celsius. Interview with the registered staff confirmed that refrigerator temperatures should be between 2 and 8 degrees Celsius.

Record review of the second floor Medication Room Fridge Temperature Log included the following temperatures:
June 3, 4, 5, and 6, 2014: 19.1 degrees Celsius
June 9, 10, 2014: 21.9 degrees Celsius
June 11, 2014: 10.8 degrees Celsius
June 12, 13, 2014: 19.3 degrees Celsius

An interview with the unit manager confirmed that the refrigerator temperatures were not within the safe range for storage of medications. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy and that complies with the manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to ensure the security of the drug supply, including the following: all areas where drugs are stored shall be kept locked at all times, when not in use.

On a specified date, the inspector observed that the medication cart, located adjacent to the nurse's station, was not locked while the registered staff was administering medications in the dining room. An interview with a nurse manager confirmed that the medication cart should be locked between medication administration.

On a specified date, the medication room was observed to be open and the medication cart was observed to be unlocked, with some drawers open, inside the medication room. There were no registered staff members in the room.

On a specified date, the medication room was observed to be open and there were no registered staff in the room.

An interview with the DON confirmed that the medication room should only be open when there is a registered staff member inside the medication room. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including the following: all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On a specified date, the inspector observed a registered staff administering medication to residents during the morning administration pass. The registered staff was observed administering an identified medication to resident #24, however, the medication was prescribed, as per the name on the label, for resident #25.

Interview with the registered staff confirmed that the identified medication prescribed for resident #25 was administered to resident #24 for whom it was not prescribed. Further, interviews with the DON, the nurse manager, and registered staff revealed that this is an accepted practice in the home.

A telephone interview with the home's pharmacist confirmed that using the same identified medication for all residents where it is prescribed is not appropriate and is not supported by the pharmacy provider. [s. 131. (1)]

2. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation

with the resident.

On two separate occasions, the inspector observed a prescribed aerosol medication to be stored within resident #320's room. On both dates resident #320 was observed to administer the drug to himself/herself.

Review of the health record and interviews held with a registered staff member and a nurse manager confirmed that a physician’s order to self-administer medication is not in place for the resident. [s. 131. (5)]

3. The licensee failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

On two separate occasions, the inspector observed a prescribed aerosol medication to be stored in resident #320's room. Review of the resident's health record and interviews held with the registered staff and nurse manager confirmed that there is no physician's order in place to permit the resident to keep the drug on his/her person or in his/her room. [s. 131. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following in regards to medication administration:

1. that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident

2. that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident and,

3. that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any policy put in place is complied with.

Review of the home's policy titled Assistance in the Dining Room, revised on March 2011, indicated that staff should not use a spoon to remove food from resident's faces; napkins and clothes protectors should be used.

On a specified date, inspector #502 and inspector #567 observed the following:

An identified PSW used a spoon to wipe food from the mouth of resident #179 while assisting with feeding.

An identified registered staff used a spoon to wipe applesauce from the mouth of resident #179 while giving medication.

An identified PSW used a spoon to wipe food from the mouth of resident #13 while assisting with feeding.

On a separate occasion, an identified PSW used a spoon to wipe food from the mouth of resident #179 while assisting with feeding.

Staff did not use a napkin or clothes protector to wipe the mouths of the residents as per home's policy. [s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On two separate occasions, the inspector observed a toilet in a communal washroom to be soiled with dried feces. An identified PSW confirmed the observation.

Interview with the environmental manager, confirmed that the toilet bowl was soiled with feces and was not properly cleaned by the housekeeper when they completed the cleaning schedule for the identified dates. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, its furnishings and equipment are maintained in a safe condition and in a good state of repair.

On three separate occasions, in an identified spa room and communal washrooms, the inspector observed the following:

- damaged and scraped wall surfaces in the spa room
- chipped paint on the door frames of the communal washrooms
- chipped paint on the door frames in the spa rooms
- tiles were broken with some areas noted to have sharp edges exposed in the spa room.

Interview with maintenance staff and the environmental manager confirmed that the spa room is in disrepair. [s. 15. (2) (c)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council minutes and interview held with the Residents' Council president confirmed that the Residents' Council does not receive a response in writing within 10 days of advising the home of any concerns or recommendations. [s. 57. (2)]

2. As confirmed by the Administrator, the home does not always respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee failed to consult regularly with the Family Council, and in any case, at least every three months.

Review of the Family Council minutes and interviews held with both the Family Council President and the Administrator confirmed that the licensee did not consult at least every three months with the Family Council. [s. 67.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

As confirmed by the Family Council President, the Council is not involved in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. As confirmed by the Administrator, the licensee does not seek the advice of the Family Council in carrying out the satisfaction survey. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

On several occasions, throughout the duration of the inspection, lingering offensive odours were noted in identified areas of a specified unit and in an identified resident bedroom and washroom.

Interviews held with registered staff, PSWs and housekeeping staff confirmed that the offensive odours were prevalent and an ongoing issue in the identified areas. Furthermore, staff confirmed that the offensive odours were brought to the attention of the environmental manager on different ocassions.

A review of the work requisition binder for the unit identified requests to clean the identified areas over an identified two month period. Despite measures taken by housekeeping staff to eliminate the odours in the main lounge and identified resident room, the odours are still prevalent.

The environmental manager confirmed the presence of lingering odours in the identified resident room when brought to his/her attention and that additional measures were not implemented to address the identified odours. [s. 87. (2) (d)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident has been investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, an investigation is to be commenced immediately.

On a specified date, resident #255 reported to the inspector that sometime between December 2013 and March 2014, a direct care staff member was rough with him/her and rushed him/her during care. The resident relayed that he/she brought the concerns forward to the nurse manager who requested that the resident provide a written complaint. Further, the identified resident confirmed that a written complaint regarding the concerns was submitted to the home.

An interview with a nurse manager confirmed that the concerns were verbally communicated by the resident's family and that the concerns were reported to the DON.

Record review and staff interviews confirmed that a written response was not provided to the resident as of the date of the inspection and an investigation was not conducted. [s. 101. (1) 1.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that any pet visiting the home as part of a pet visitation program has up-to-date immunizations.

Review of the vaccination records provided by the home for a visiting dog were out-of-date. As a result, the home was not able to provide documentation to confirm that the following required immunizations were current: rabies, distemper, hepatitis, parvovirus and parainfluenza,leptospirosis and heartworm. [s. 229. (12)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_102116_0012	116

Issued on this 9th day of September, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs