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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2019	2018_726724_0007	028274-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

MIKO HAWKEN (724), COREY GREEN (722), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 25, 26, 29, 30, and 31, 2018. November 1, 2, 5, 6, 7, 8, 2018.

The following intakes were completed during this inspection:
Log #027033-17 - Complaint related to infection prevention and control.
Log #009648-17 - related to a resident fall.
Log #003633-18 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Care (DOC), Director of Environmental Services, Housekeeper, Food Service Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aide (PCA), Family Council President, Resident Council President, residents and their families.

During the course of the inspection, the Inspectors conducted a tour of the home, made observations of: meal services, medication administration and storage area, staff and resident interactions, provision of care, conducted reviews of health records, and CIS logs, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

During the tour of the home on a specific date, Inspector #570 observed the following:

- an enclosed balcony in a resident home area on an identified floor, had unlocked doors leading to the balcony from the kitchen and from the residents common sitting area. The balcony was accessible to all residents and did not have a resident-staff communication and response system available.

- the general store located on main street was attended by a resident volunteer and the store was accessible to all residents. The store was used by residents to buy food items, snacks and other items and did not have a resident-staff communication and response system available for residents to call for help if necessary.

During an interview with Inspector #570 on a specific date, RPN #109 indicated that ambulatory residents can go on to the balcony when it is not snowing or raining. The RPN indicated the two doors to the balcony will be unlocked in the morning. The RPN confirmed that there was no resident-staff communication and response system available for residents to call for help if necessary and further indicated that staff would keep an eye on residents every 15 to 30 minutes.

On a specific date, during an interview with Inspector #570, the Assistant General Manager (AGM) confirmed that there was no resident-staff communication and response system available for the balcony in a home area and for the store on main street.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by the residents [s. 17. (1) (e)]

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 equipped with a resident-staff communication and response system that (e) is available in every area accessible by residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Related to Log#009648-17.

On a specific date and time, the home submitted a Critical Incident Report to the Director related to improper/ incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR indicated that on a specific date and time, PCA #106 did not put the safety seatbelt on when showering resident #012 when using the Carendo shower chair. As a result the resident slipped off of the shower chair, fell to the floor and sustained an injury.

A review of the progress notes for resident #012 indicated an entry on a specific date, by RPN #113 that the seatbelt was off while the resident was sitting in Carendo chair having a shower. Also, the progress notes review revealed that the resident sustained injuries.

A review of the licensee's policy "Carendo Shower Chair", Policy number: 04-06B indicated:
2. Safety belt is to be attached to the back rest of the chair. The proper use of the safety belt will ensure that the resident is upright in the center of the chair, and is not leaning too forward or backward. At no time is the resident to be on the chair without a safety belt.

During an interview with Inspector #570 on a specific date, PCA #106 indicated that on a specific date, they assisted resident #012 with their shower. PCA #106 stated that they did not apply the safety seatbelt when showering resident #012 and thought at that time that the resident did not need to use the seatbelt.

On a specific date, during an interview with Inspector #570, the Director of Care (DOC) indicated staff should use safety seatbelt when using the Carendo chair to shower residents and is also required by the home's policy. The DOC acknowledged that it was unsafe positioning of the resident when the staff did not apply the seatbelt while showering resident #012 in the Carendo Chair.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted resident #012. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the Resident Quality Inspection (RQI), resident #004's census record review identified on specified date that they had an alteration of skin integrity.

A clinical record review of resident #004 indicated that on a specific date the resident was assessed using the homes "Skin Observation Tool – SV2 – V2" in Point Click Care

(PCC) to have an alteration of skin integrity. No further skin observations or assessments were completed for the altered skin integrity after this finding.

During an interview on a specific date by Inspector #724 with Registered Practical Nurse (RPN) #127 indicated that when an an area of altered skin integrity is found on a resident, it is to be assessed using the "Skin Observation Tool" for skin assessments which is found in Point Click Care (PCC) and it is to be completed weekly until it is healed. During the interview, Inspector #724 had shown resident #004's assessment in PCC. RPN #127 indicated that there were no further assessments completed as required since the original skin assessment completed by them on a specific date.

In an interview on a specific date with the Director of Care (DOC), they indicated the expectation for registered staff is to complete an as needed (PRN) skin assessment when there is a change in skin integrity to a resident. The DOC further indicated that staff are to complete skin assessments using the "Skin Observation Tool" in PCC weekly until the area of altered skin integrity is healed. During the interview Inspector #724 showed the DOC resident #004's original skin assessment from a specific date and the DOC indicated that the registered staff failed to complete weekly follow up skin assessments until the alteration in skin integrity had healed as per legislation.

The licensee failed to ensure that a weekly skin assessment using the "Skin Observation Tool" in PCC was completed by registered staff when a resident exhibited altered skin integrity. [s. 50. (2) (b) (iv)]

2. During stage one of the Resident Quality Inspection (RQI), resident #009's census record review identified an alteration of skin integrity.

A clinical record review indicated on a specific date, a skin assessment was completed using the homes "Skin Observation Tool" in PCC for resident #009. The skin assessment indicated that resident #009 had an alteration of skin integrity.

Further review of resident #009's clinical records indicated that another skin assessment was completed using the "Skin Observation Tool" in PCC on a specific date which indicated that the alteration in skin integrity was healed. No other weekly skin assessments were found for resident #009 between a specific date and a specified date which should have been completed every seven days, on specific dates identified.

On a specific date, during an interview with RPN #107 indicated the expectation for

registered staff is to complete a skin assessment using the "Skin Observation Tool" when there is a change in the skin integrity of the resident and that it is to be completed weekly until it is healed.

In an interview conducted on a specific date with the DOC, they indicated the expectation for registered staff is to complete a skin assessment, as needed, when there is a change in skin integrity to a resident. DOC #103 further indicated that staff are to complete skin assessments using the "Skin Observation Tool" in PCC weekly until the area is healed. During the interview Inspector #724 showed the skin assessments for a specific date and a specific date with the DOC. The DOC indicated that the registered staff failed to complete weekly follow up skin assessments as per legislation on specific dates identified.

The licensee failed to ensure that a weekly skin assessment using the "Skin Observation Tool" in PCC was completed by registered staff when a resident exhibited altered skin integrity. [s. 50. (2) (b) (iv)]

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving advice from the Family Council related to concerns or recommendations.

During the review of the Family Council (FC) meeting minutes as part of this Resident Quality Inspection (RQI), Inspector #722 identified a number of concerns and/or recommendations that were brought to the attention of the licensee, where there was no response in writing provided by the licensee to the Family Council.

The Family Council (FC) Chair was interviewed by Inspector #722 on a specific date, who indicated that the FC has typically made recommendations and raised concerns to the licensee using the Family Council Response Form (FCRF). The Chair indicated that the licensee has provided their written responses on the FCRF, including a description of the actions taken. The Chair indicated that the completed FCRF has typically been sent to them by email to be reviewed, and filed in the FC binder.

On a specific date, with permission from the Family Council Chair, Inspector #722 reviewed the FC binder from a specific month, to present. Inspector #722 identified minutes for FC meetings that occurred on specific dates as well as completed FCRFs corresponding to various concerns raised and/or recommendations made at some of those meetings.

When the FC binder was reviewed, Inspector #722 was unable to locate any written responses, on the FCRF or any other form of written communication, provided by the home for the following nine concerns and recommendations:
- On a specified date: resident with respiratory symptoms attended a group activity while the resident home area was on outbreak
- On a specified date: Cleanliness (dirt/dust) in a resident home area; lack of parking, truck parked all winter
- On a specified date: Cleanliness (coffee/food stains) in resident home area; binder suggested for tracking missing items
- On a specified date: Changing residents when incontinent more often, including outer clothing
- On a specified date: Lip at front door in sidewalk, smoking at front door, and overflowing garbage can

During a follow-up telephone interview with Inspector #722 on a specific date, the Chair

confirmed that there were no FCRFs available for the issues and/or recommendations noted above, and indicated that they did not recall receiving any other form of written response from the home (e.g., email, formal letter).

The home's AGM was interviewed by Inspector #722 on a specific date, related to the Family Council (FC). During the interview, the AGM acknowledged that the FC has raised concerns and made recommendations to home staff who have been invited and attended FC meetings, and confirmed that the FCRF was the usual method used by the home to provide a written response to the FC.

During the interview, the AGM also indicated that they had started in the role on a specific date, and was unable to locate a written response for the issues raised at the specific month's meetings. The AGM confirmed that there was no FCRF completed for the issues identified above that were raised at these specific months' meetings. In a follow-up interview with Inspector #722 on a specific date, the AGM confirmed that the home had not provided any other response in writing (i.e., email, formal letter) to the Family Council related to those issues, and confirmed that the expectation is that the response should have been provided on the FCRF.

The licensee has failed to ensure that they responded in writing within 10 days of receiving advice from the Family Council related to nine issues that were provided to the home during the Family Council meetings in for the specific months indicated. [s. 60. (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 if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #5: 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 has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey.

The Family Council (FC) Chair was initially interviewed by Inspector #722 on a specific date, related to activities of the Family Council. During the interview, when asked how the home has included the Family Council in developing and carrying out the satisfaction survey, the Chair indicated that they recalled seeing the survey, and a report on the results of the survey. The Chair indicated that the FC had not been asked about the questions in the satisfaction survey and/or how the survey is carried out.

With permission from the FC Chair, Inspector #722 reviewed the FC meeting minutes for specific dates. During the meeting on a specified date, the minutes indicated that the management provided an update about the results of the 2017 and 2018 satisfaction survey. There were no other agenda items and/or documentation in the FC meeting minutes in 2018 that indicated that the satisfaction survey had been shared with the FC prior to implementing the survey, or that the FC had been consulted on how the survey was to be carried out.

The AGM was interviewed by Inspector #722 on a specific date, related to the home's Family Council (FC). During the interview, the AGM indicated that the satisfaction survey is based on questions developed and provided to the home by corporate head office (Schlegel Villages Inc.), and indicated that the same standardized questions are used across all the licensee's homes. The AGM explained that the satisfaction survey is administered to groups of residents each month throughout the year, and results are released to the home twice per year. The AGM indicated that if they receive feedback on a question from a resident or family member, they can send that to corporate office for revisions, but that it's difficult.

When asked during the interview on a specific date, if the home has provided the satisfaction survey questions to the Family Council for review, the AGM indicated that

they were not aware of that happening since they began employment in the home. The AGM also indicated that the review of the resident satisfaction survey during the FC meeting in a specific month, was more focused on results, but suggested that the FC could provide feedback on the questions in the survey during the review of the results. When asked if the FC was provided an opportunity to give feedback on developing and carrying out the resident satisfaction survey, the AGM indicated that they could be more deliberate about it, clearly have the discussion, and make sure that it is documented to meet the standard. The AGM acknowledged that the discussion about the development and implementation of the satisfaction survey with the FC needs to be more deliberate.

The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

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 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure residents receive fingernail care, including the cutting of fingernails.

During stage one of the Resident Quality Inspection (RQI) during resident observations, resident #004 was identified as having finger nails that were not cared for.
The homes most recent policy on "Spa (Shower, Tub Bath, Sponge Bath)" (Tab 04-06) from the Schlegel Villages policies and procedures, indicated that during the procedure of a shower/tub bath/sponge bath a Personal Support Worker (PSW) will:
-After bathing is completed, provide nail care to feet and hands.
-Document type of spa provided and the level of assistance provided on the PSW flow sheet, including nail and skin care or in the electronic documentation system where Point of Care (POC) is in use.

During multiple observations of resident #004 on specified dates, it was observed by Inspector #724 that the resident had finger nails that were not cared for.

A review of resident #004 most recent written care plan on a specific date did not indicate any interventions related to finger nail care. A "look back" report of resident #004 in Point of Care (POC) in PCC for 16 days from specified dates, indicated that there was no finger nail care provided.

In an interview with RPN #127 on a specific date they indicated that the finger nails were to be cared for on the resident's bath day by the PCA and that this information was to be found in the care plan. Inspector #724 reviewed resident #004's care plan with RPN #127 and there was no indication of finger nail care found within the care plan. During the interview with RPN #127, they were brought to resident #004 by Inspector #724 and was shown the condition of the resident's nails. They indicated that the condition of resident #004's finger nails was unacceptable.

During an interview with the DOC on a specific date, they indicated that the PCA's were responsible for finger nail care on bath days, as indicated in the care plan. Inspector #724 reviewed resident #004's care plan and POC documentation with the DOC. They indicated that there were no interventions indicated under "Bathing" for finger nail care and there was no documentation found in POC that this was completed by any PCA's.

The licensee failed to ensure that finger nail care was provided, including the cutting of nails. [s. 35. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)

(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee had failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted.

On a specific date, Inspector #570 conducted the initial tour of the home. During the initial tour, the Inspector reviewed the home's posted Ministry of Health and Long Term Care (MOHLTC) reports for the past two years which were placed in clear wall file holders attached to the communication board located on Main Street of the home.

The following MOHLTC inspection reports were not posted:
- Resident Quality Inspection: report #2016_195166_0037
- Resident Quality Inspection: report #2017_640601_0011

An interview was carried out on a specific date, with the Assistant General Manger (AGM). The AGM was informed of the inspector's observations and the AGM searched the area and the wall mount file holder that included the MOHLTC inspection reports and acknowledged that the two reports indicated above where not posted. [s. 79. (3) (k)]

WN #8: 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 has failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

During stage one of the Resident Quality Inspection (RQI), Inspector #722 observed a number of potentially hazardous substances on top of two large storage bins in the resident's washroom, beside the toilet.

On a specific date, Inspector #722 identified hazardous items stored in the washroom that resident #001 shares with one other co-resident.

Resident #001 was interviewed by Inspector #722 on a specific date, and confirmed that the hazardous items stored in the washroom belonged to the resident.

Inspector #722 reviewed the home's policy on Handling, Storing, and Disposing of Hazardous Chemicals (Schlegel Villages, Occupational Health and Safety, Tab 08-05), which indicated the following: 3. Any material or chemical that possesses hazardous properties will be handled, stored and disposed of in a manner that is safe, complies with WHMIS or other regulations, and that does not pose a hazard.

On a specific date, Inspector #722 notified the Director of Environmental Services (DES) of the items identified in the resident's washroom; the DES indicated that these would be considered hazardous substances and should be stored in a locked cabinet. The Director of Environmental Services indicated that action would be taken and the identified items would be removed from the resident's washroom.

On a specific date, Inspector #722 interviewed the AGM, who indicated that the items stored in resident #001's shared washroom would be considered hazardous materials and that the expectation is that these items are either not in the building, or are locked and inaccessible to any resident. The AGM indicated during the interview that all of the hazardous substances identified above were removed from the resident's washroom on a specific date, and moved to a locked storage cabinet.
The licensee has failed to ensure that hazardous substances in resident #001's washroom were kept inaccessible to residents at all times. [s. 91.]

Issued on this 10th day of January, 2019

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

Original report signed by the inspector.