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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2014	2014_312503_0018	T-112-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

WESBURN MANOR
400 The West Mall, ETOBICOKE, ON, M9C-5S1

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

LAURA BROWN-HUESKEN (503), JOELLE TAILLEFER (211), SUSAN SQUIRES (109), VALERIE PIMENTEL (557)

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): August 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, and September 5, 2014.

During the course of the inspection, the following critical incident, complaint and follow-up inspections were completed: T-672-13, T-600-14, T-740-14, T-897-14, T-1006-14, and T-1129-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), acting director of care (ADOC), nurse managers, acting nurse manager, resident assessment instrument (RAI) coordinator, registered nursing staff, personal support workers (PSW), nutrition managers, registered dietitian, cooks, food services workers (FSW), social worker, acting resident services manager, administrative services supervisor, building services supervisor, rehabilitation assistant, recreation assistant, custodian, Residents' Council president, Family Council president, family members and residents.

During the course of the inspection, the inspector(s) conducted tour of all home areas, observed meal services and meal production, reviewed clinical records, observed provision of care, reviewed Residents' Council minutes and Family Council minutes, home's specified policies, reviewed the complaint log, maintenance records, air temperature logs, recreation calendar and education records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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 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 each resident exhibiting altered skin integrity, received 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.

Resident 8 had two pressure ulcers. The home had an assessment tool which was to be completed for each wound on a weekly basis. Record review and staff interviews revealed that there were no skin assessments completed on the home's assessment tool for one of the pressure ulcer for six identified weeks. There are no skin assessments completed on the home's assessment tool for the other pressure ulcer for one identified week. This was confirmed by the ADOC. [s. 50. (2) (b) (i)]

2. Record review and resident observation revealed resident 33 had altered skin integrity. The home used a specific weekly ulcer/wound assessment record which is to be completed for each wound. Record review and staff interviews indicated that the skin assessments were not completed using the home's skin assessment tool for an identified one moth period, after the doctor prescribed a treatment for the wound. This was confirmed by the ADOC. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that each resident who is exhibiting altered skin integrity, including wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Record review and resident observation revealed resident 33 had altered skin integrity. On an identified date, the resident had a surgical procedure for the wounds and a treatment was prescribed. Record review and staff interviews revealed that the resident did not receive weekly skin assessments by a member of the registered nursing staff for the wound from the identified date, when the treatment was ordered until one month later, when the treatment was discontinued. This was confirmed by the ADOC. [s. 50. (2) (b) (iv)]

4. Record review and staff interviews revealed resident 54 was identified to have a pressure ulcer and had a prescribed treatment in place. Record review and staff interview revealed the last weekly skin assessment which was completed on an identified date, described the wound as healing. There are no other assessments completed after this date. Staff interview revealed that the wound healed on an unidentified date. There was no indication as to when this wound healed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with.

Review of the homes' policy titled Medications – Off-Hours Medication Supply, PH-0109-00 revised January 6, 2012, directed staff to count the off-hours medication supply on a bi-weekly basis by two registered staff.
There were two different Off-hours Medication Supply Control Sheet observed and used interchangeably. Form #81-6361-10-05 included drugs that were not stocked in the off-hours medication supply. This form included Tylenol #3 which was no longer stocked. When used, the form required manual changes including striking out Tylenol #3 and adding in Tylenol #2.
The inspector observed the form for July 24, 2014 and noted that the Tylenol #3 had not been manually changed to read Tylenol #2. The registered nursing staff and nurse manager both signed off as counting Tylenol #3. Interview with the registered nursing staff confirmed that it was Tylenol #2 and the manual change to the record did not occur.
The inspector observed and record review revealed the registered nursing staff were not counting the off-hours medication on a bi-weekly basis. The off-hour medication supply control sheets were reviewed from March 26, 2014 to August 22, 2014. The bi-weekly count was not completed for the following periods:

- May 24 and June 10, 2014,
- June 10 and July 7, 2014,
- July 24 and August 22, 2014.

Staff interviews with the registered nursing staff and the ADOC confirmed that the home's policy for counting the off-hours medication supply did not occur on a bi-weekly basis and that the correct form was not consistently being used. [s. 8. (1) (b)]

2. The home's policy titled Narcotic and Controlled Substances PH-0106-00, published January 6, 2012, indicated that two nurses, one from the outgoing shift and one from the oncoming shift, will count narcotics and controlled substances utilizing Narcotic and Controlled Substances Record. The policy directs staff to record the declining balance on the narcotic record and maintain this record in front of the medication administration record (MAR) for the individual resident. Interviews with identified registered staff revealed that a narcotic blister pack containing 25 Percocet tablets was missing on an identified date. The identified registered staff members indicated that the narcotic blister pack was signed for but not always counted with two registered staff over a one month period. The missing blister pack was accounted for two days prior. During the three shift changes on an identified date, and the 7:00 a.m. shift change the following day, the outgoing and incoming registered staff members signed for the blister pack but reported they did not count. A total of four registered staff reported that they did not complete the count or did not complete the count with a second registered staff member present. At the 3:00p.m. shift change on the day that the 25 Percocet tablets were noted missing the outgoing registered staff signed for the blister pack but did not count. The incoming registered staff completed the count independently and noted the blister pack missing and reported this to the home's management.

Interview with the nurse manager revealed that the police and the Director were immediately notified regarding the missing narcotic. The home's internal investigation had not been completed at the time of the inspection. Interview with nurse manager and acting director of care confirmed that registered staff had not followed the narcotic and controlled substances policy. [s. 8. (1) (b)]

3. The home's policy titled "Destruction of Discontinued Narcotic and Controlled Medication", PH-0231-00 dated January 6, 2012, stated to place all discontinued narcotics and controlled substances for individual residents in a separate paper bag, to staple the surplus medication control sheet to the paper bag and to place in the designated storage area. The policy further directed staff to destroy discontinued narcotic and controlled medications on a monthly basis.

The inspector observed in a cupboard within the 3rd floor north medication room the following:
- three boxes of Diastat discontinued on April 25, 2013,
- two vials of Morphine discontinued on June 18, 2013.
These medications were not secured in an individual paper bag. The Diastat did not have a medication control sheet affixed to it. The medications were not placed in the Medical Pharmacy destruction box.

The registered nursing staff and the ADOC confirmed that these medications should have been destroyed at the time they were discontinued and the procedure for destruction should have been followed. [s. 8. (1) (b)]

4. Record review of the home's policy titled Care of Resident with a Gastrostomy/Enteral Tube, NU-0802-00 published January 12, 2010, directed staff to document on the enteral feed-intake bedside worksheet the amount of the enteral feed intake each shift, the water intake each shift, the amount of water used for flushing medication manually, and fluid volume of medications administered in elixir form.

Record review for resident 58 indicated that the sheets over an identified 24 day period were not properly completed. The day shifts did not document for eight days, the evening shifts did not document for 22 days and there is no documentation completed by the night shifts over the 24 day period. The total amount of enteral feed and water administered daily were not documented. Interview with the DOC confirmed that the enteral feed-intake bedside worksheet was not properly completed and the home's policy was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 August 7, 2014, inspectors observed that one section of the south side of the 3th floor was under renovation. The carpet was observed to have been removed but pieces of the carpet remained glued on the floor. The edges of the carpet were raised posing a trip hazard and one resident was walking without supervision in the area. On August 27, 2014, inspectors observed that a large paper backing from the newly installed flooring was left unattended on the hallway floor to the 4th floor south side outside the recreation and complementary care offices and the nursing station posing a trip hazard. Management staff confirmed that the area was not safe and secure for the residents and immediately secured the area. [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 when construction work is undergoing in the home, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 there is a written plan of care for each resident that sets out the planned care for the resident.

Interviews with resident 18 and an identified rehabilitation assistant revealed that the

resident attends two identified rehabilitation programs weekly. Review of the activity attendance forms confirmed the resident's attendance in these programs. The resident's written plan of care outlined the planned care for one of the programs, however did not outline the other program. The rehabilitation assistant and the acting resident services manager confirmed that both programs should have been outlined as planned care in the resident's written plan of care. [s. 6. (1) (a)]

2. An interview with an identified recreation assistant (RA) revealed that resident 31 attends identified activities. The RA further revealed that the resident requires encouragement from staff and sometimes from family members to attend programs. Review of the activity attendance forms confirmed the resident's attendance in the programs. Review of the resident's written plan of care, revealed that it did not outline the planned care for participation in these programs or strategies to promote participation. The RA and the acting resident services manager confirmed that participation in these programs and strategies to promote participation should have been outlined as planned care in the resident's written plan of care. [s. 6. (1) (a)]

3. Interviews with direct care staff revealed that the staff are cleaning the teeth of resident 69 using a toothette and mouthwash. Observation of the resident's bathroom revealed that the resident has different oral care equipment. Review of the resident's written plan of care revealed that the plan did not include directions for staff related to the frequency or technique for oral hygiene for the resident. An interview with an identified nurse manager confirmed that the written plan of care did not include planned oral hygiene for the resident. [s. 6. (1) (a)]

4. The licensee failed to ensure that the written plan of care for each resident sets out clear directions to the staff and others who provide care to the resident.

Resident 38 was observed to be using a hearing device and was able to have a conversation with the inspector. The resident stated that he/she has been using the device for about one year. Staff interviews revealed the staff were unaware of the device that the resident uses to hear conversations. Record review of the plan of care revealed that the resident uses a different device that the staff must assist him/her with it in the morning and the evening. The plan of care does not provide clear directions to the staff and others who provide care to the resident in relation to the type of hearing device to be used. [s. 6. (1) (c)]

5. Resident 69 requires a special treatment every week. The treatment was

administered by the registered nursing staff. Record review of the medication administration records revealed that the directions stated to administer the treatment once a week. Record review of the written plan of care revealed that the treatment was to be administered every two weeks. Interview with the staff confirmed that the written plan of care does not provide clear directions with respect to the frequency of care for the resident. [s. 6. (1) (c)]

6. Record review of the written plan of care for resident 69 does not indicate the bathing preferences for the resident. A progress note from an identified date indicated that the resident was screaming and did not like the identified bathing method. Interview with a family member indicated the resident's bathing preference, however the staff interview revealed the resident is not bathed as per this preference. The written plan of care did not provide clear directions for the staff bathing the resident. [s. 6. (1) (c)]

7. The Diet Information List located in the servery, from an identified date, noted an identified food preference of resident 31. On the same list, in the do not serve column, a similar item was listed. An interview with a nutrition manager revealed the resident's preference and that the Diet Information List did not provide clear directions to serving staff. [s. 6. (1) (c)]

8. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Record review of the written plan of care from an identified date, indicated that resident 42 required transfer with a Hoyer lift with two staff in and out of bed, and two staff to guide the resident during toileting transfer. The minimum data set (MDS), from an identified date, indicated that resident's full assessment for transfer was total dependence and two persons for physical assistance. The ad hoc conference notes from an identified date, indicated that the resident required complete assistance with one person for toileting and transferring. The physiotherapy quarterly re-assessment from an identified date indicated that the resident required moderate assistance with one person for transfer.
Staff interview confirmed that the staff and others involved in the different aspects of care of the resident did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated

and are consistent with and complement each other. [s. 6. (4) (a)]

9. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Record review of the physician's order for resident 6 stated to administer a specified medication prior to morning care. Interviews with the PSWs indicated that some days the resident was provided morning care at 6:00 a.m. and other days the care was provided at 7:00 a.m. The medication administration records (MAR) indicated that the medication was to be administered at 8:00 a.m.

Staff interviews with the PSWs and registered nursing staff confirmed that the resident received morning care prior to receiving the medication. The medication was not provided as per directions for use as specified by the prescriber. The staff did not collaborate with each other to ensure the residents care was integrated, consistent and complemented each other. [s. 6. (4) (b)]

10. The licensee failed to ensure that the resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Interview with the resident's substitute decision-maker (SDM) indicated that shortly after the resident was admitted to the home, the SDM requested that the resident's teeth be brushed using identified oral care equipment which were provided by the family. Observation of the resident's bathroom revealed that the resident had the equipment. Review of care conference notes from an identified date revealed that the attendees discussed the SDM's request for having the resident's teeth brushed after meals. Review of the resident's written plan of care revealed that the plan did not incorporate the SDM's request for oral hygiene after meals or the use of the identified equipment. An interview with an identified nurse manager confirmed that the request for the frequency of oral hygiene was not incorporated into the resident's plan of care and should have been included based on the SDM's request. [s. 6. (5)]

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

On an identified date resident 33 had a change in health condition. The resident was assessed by the physician and an x-ray was ordered. Record review revealed that the x-ray was not completed. Staff interviews with the registered nursing staff and nurse manager confirmed that the x-ray was not completed and the resident's plan of care was not provided as specified. [s. 6. (7)]

12. Record review of the written plan of care from an identified date, indicated that resident 42 required two staff and a Hoyer lift to transfer resident in and out of bed. The written plan of care indicated that resident needs assistance of two staff for toileting and guidance for transfer on and off the toilet. Interview with an identified staff member indicated that she/he did not review the written plan of care prior to transferring the resident. The resident was transferred with one staff to the toilet and to bed.
Staff interview confirmed that the written plan of care indicated that the resident was to be transferred with the Hoyer lift and two staff in and out of bed and two staff to guide resident during toileting transfer. [s. 6. (7)]

13. Record review of the written plan of care for resident 41 indicated that two staff are required for toileting. The resident complained that an identified staff was rough and hurt her/his affected arm during the transfer. Staff interview confirmed that the resident was transferred with one person assistance and used the resident's affected arm to lift the resident while transferring after toileting. Interview with nurse manager confirmed that the resident required two staff assistance for toileting and the written plan of care was not followed. [s. 6. (7)]

14. Record review of the form titled Feeding Prescription and Water Administration revised August 1, 2014, provided enteral feeding instructions for staff related to resident 58. An interview with registered staff revealed that on an identified date the resident did not received the enteral feed as directed. Interview with the DOC confirmed that the resident was not receiving the proper amount of enteral feeding in 24 hours as specified in the plan of care. [s. 6. (7)]

15. Record review of the written plan of care for resident 58 on an identified date, directed staff to label both feed and water bag with date, time and initials each time a new bag is hung. The enteral feeding bag and water bag were observed on September 5, 2014, to be hung without labels. Interview with the registered staff and the DOC confirmed that the enteral feeding bag and water bag were not labeled as specified in the plan. [s. 6. (7)]

16. The licensee has failed to 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 the resident's care needs change.

Record review indicated that during a care conference on an identified date, resident 22 had been identified to have altered skin integrity. During the care conference it was recommended that the resident would start using a specified skin care lotion. After the care conference, the nurse did not contact the family to request the lotion as discussed. The plan of care had not been revised in response to this new intervention. Two days later, staff interview confirmed that the family had not been asked to provide the lotion as discussed at the care conference. Staff interview also confirmed the plan of care had not been revised to reflect the changes to the interventions. [s. 6. (10) (b)]

17. Record review and staff interview revealed resident 54 had altered skin integrity and had a prescribed treatment in place. Record review revealed the last weekly skin assessment was completed on an identified date, which described the wound as "healing". There are no other assessments completed after this date. Staff interview revealed the wound healed at an unidentified time. The treatment continued to be signed off as having been administered to the resident as prescribed as of an identified date, however the staff confirmed the wound was healed and treatment was no longer required. There has been no change to the plan of care in response to the change in the resident's altered skin integrity. [s. 6. (10) (b)]

18. The quarterly MDS from an identified seven month period, indicated that resident 23 was occasionally incontinent of bowel. The written plan of care effective from an identified 10 month period indicated that the resident was continent of bowel with complete control. Staff interviews and record review revealed that the resident was occasionally incontinent of bowel. Interview with the nurse manager confirmed that the written plan of care under the bowel continence section was not reviewed and updated during the 10 month period to reflect resident's care needs. [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 there is a written plan of care for each resident that sets out the planned care for the resident and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the home and equipment are maintained in a good state of repair.

Observation revealed paint chips, scuffs and drywall holes in the common area in the Silverthorne Way. Interview with the painter and the department manager revealed there was not a formalized schedule in place to determine what and when painting will occur in a particular area. Interview with the painter revealed that he paints an area when he observes the area to be in need of painting which includes the lounge areas. The painter stated that his records of the areas that he paints was misplaced and he had not been tracking the areas that he had painted for the past three weeks. [s. 15. (2) (c)]

2. On August 08, 2014, the inspector and a staff member observed that the raised toilet seat was loose in the resident's bathroom of an identified room. The staff member was unable to secure the raised seat properly on the toilet and stated that it needs to be replaced. Later during the same day, the inspector observed that the seat was replaced. The maintenance staff confirmed that the seat in resident's bathroom was loose and it was replaced. [s. 15. (2) (c)]

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 and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #6: 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 the person who had reasonable grounds to suspect that that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Record review and staff interviews revealed that on an identified date, a staff member received a complaint from the SDM for resident 42 indicating that the resident was treated in a rough fashion. Record review indicated that the investigation of alleged abuse was started on an identified date, but the Director was not informed until three days later. Interview with the administrator confirmed that the Director was not informed immediately. [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 the person who had reasonable grounds to suspect that that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming.

Interview with the family of resident 69 revealed that the resident does not like to be bathed in an identified manner because he/she is afraid and did not bathe in the identified manner prior to admission to the home. Interview with the staff revealed that they are unable to determine why the resident was bathed in that manner in the home and suggested that perhaps it was related to the resident's physical disabilities. There was no clinical assessment to determine whether or not the resident was able to bathe in his/her preferred method. There had been no attempt by the staff to bathe the resident in his/her preferred method. [s. 26. (3) 7.]

2. The licensee failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the resident with respect to hydration status and risks relating to hydration.

Review of the plan of care for resident 38 revealed that hydration status and risks associated with hydration were not included within the plan. Clinical documentation from an identified date, indicated that the resident was consuming an identified amount of fluid per day. An interview with the RD revealed that the resident had an assessed fluid need greater than what was being consumed as indicated on the quarterly nutrition review. The RD further confirmed that despite the resident's fluid intake being less than 75% of his estimated needs, his/her hydration status and risk for dehydration were not assessed in the dietitian assessment from an identified date, and were not included in the resident's plan of care. [s. 26. (3) 14.]

3. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment with respect to altered skin integrity.

Record review revealed that resident 33 was being treated for altered skin integrity. Record review and staff interview revealed there is no plan of care developed in response to the interdisciplinary assessment of the resident's altered skin integrity. [s. 26. (3) 15.]

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 is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming, hydration status and risks relating to hydration and altered skin integrity, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

During a lunch observation on August 7, 2014, resident 63 was provided with puree texture omelette and salad. Review of the therapeutic spreadsheet revealed that the lunch menu included puree texture omelette, salad and bread. An interview with the nutrition manager confirmed that the resident had not been served according to the planned menu including the pureed bread product and that there were no exceptions based on the resident's plan of care. [s. 71. (4)]

2. During a lunch observation on August 8, 2014, resident 8 was observed to be provided an entrée. An interview with an identified PSW confirmed that the resident was not offered or provided soup prior to the entree. Once identified by the inspector, the PSW provided the resident with the course of soup. An interview with an identified nutrition manager confirmed that the resident should have been provided soup as per the planned menu. [s. 71. (4)]

3. During the lunch meal preparation observation, an identified cook was observed to reheat puree beef which had been left over from the previous day's barbeque. The daily lunch menu included meatloaf. An interview with the cook revealed that the puree beef was used alongside the puree meatloaf as they are similar products. An interview with an identified nutrition manager confirmed that puree beef was not part of the planned menu. [s. 71. (4)]

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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).**

**s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).**

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized food production system in the home that provides for standardized recipes and production sheets for all menus.

Review of the recipe of the puree sautéed spinach and onions revealed the recipe did not include method of preparation, cooking time or temperature. The home's Standardized Recipes policy, FN-0206-00 revised July 1, 2010, indicated that standardized recipes are to include methods of preparation, cooking time, total yield, temperature, serving sizes and quantity of ingredients. Interview with an identified nutrition manager confirmed that the recipe did not include all required information for preparation of the product. [s. 72. (2) (c)]

2. The licensee failed to ensure that there is an organized food production system in the home that provides for preparation of all menu items according to the planned menu.

During the lunch meal preparation observation, the home's cook was observed to place the pureed meatloaf into the steamer without removing it from it's packaging. The standardized recipe for the puree meatloaf directs staff to follow manufacturer's

instructions to reheat product. Review of the manufacturer's cooking instructions, obtained from the manufacturer, revealed that if the product is pouched, it is to be removed from packaging and transferred to a stainless steel container and tightly covered with tin foil when placing in a steamer. Interview with staff and management revealed that the staff were not aware of the manufacturer's cooking instructions and that they were not available in the home.
The cook was observed to reheat puree beef which had been left over from the previous day's barbeque. Review of the standardized recipe for the puree beef directs staff to discard unused portions. The August 14, 2014, lunch menu included meatloaf. The standardized recipe directed staff to prepare puree meatloaf. An interview with an identified nutrition manager confirmed that the puree beef had not been prepared according to the standardized recipe as part of the planned menu and was not on the day's menu.
The cook was observed to prepare whipped turnips without consulting the standardized recipe. The cook was observed to add an unmeasured amount of onion powder, margarine, and vegetable soup base to the product, and did not add diced potato or sugar. A review of the standardized recipe revealed specific quantities of diced potato, sugar and margarine, and the recipe did not include onion powder or vegetable soup base.
The cook was observed to prepare the vegetable quiche. The cook was observed to mix unmeasured ingredients together prior to filling the uncooked pie shells. Review of the standardized recipe revealed that the pie shells were to be baked for 10 minutes prior to filling.
The cook was observed to prepare the cream of potato soup. The cook was observed to mix unmeasured ingredients, including garlic powder, into the soup. Review of the standardized recipe revealed specific quantities of each ingredient and the recipe did not include garlic powder.
An identified FSW was observed to add instant chicken gravy mix and instant brown gravy mix to water during the preparation of the brown gravy. A review of the standardized recipe revealed that the brown gravy was to be prepared using instant brown gravy mix and water.
An interview with an identified food services manager confirmed that for each of the aforementioned recipes, the standardized recipe had not been followed as part of the planned menu. [s. 72. (2) (d)]

3. During an observation of the lunch meal preparation, the cook was observed to prepare whipped turnips, spinach and meatloaf using the robot coupe. In between preparation of each of the items the robot coupe was rinsed with water. The cook was

further observed to rinse the thermometer with water in between taking the temperature of prepared food items. The home's Food Preparation and Service policy, FN-0207-00 reviewed September 1, 2013, indicated that all preparation and service equipment is to be washed and sanitized before use. An interview with a nutrition manager confirmed that the robot coupe should be sanitized between each use to prevent contamination of foods being prepared and that the thermometer should be cleaned with sanitizing wipes between each use to prevent contamination. [s. 72. (3) (b)]

4. The licensee failed to ensure that the staff of the home complies with the cleaning schedule for the food production area, servery and dishwasher areas.

The August 2014 Food Service Worker Cleaning Monthly schedule, which outlined the cleaning tasks for the home's kitchen, directed staff to remove and wash shelves in the holding fridge on Thursdays. This task was not signed as being completed on Thursday August 28, 2014. Observation of the holding fridge on Friday August 29, 2014, revealed visible dirt and debris on the shelves. An interview with an identified food service worker confirmed that the shelves were visibly dirty and should have been cleaned the prior day. Of the 51 tasks that staff were directed to complete between August 1, 2014, and August 26, 2014, there were 25 tasks not signed as completed.

The August 2014 Food Service Worker Cleaning Monthly Schedule, which outlined the cleaning tasks for the second floor servery and kitchenette, directed staff to clean and sanitize the servery walls on Thursdays. This task was not signed as being completed on Thursday August 28, 2014. Observation of the servery walls on Friday August 29, 2014, revealed visible food debris on the walls and that the wall was sticky to the touch. An interview with an identified food service worker confirmed that the walls were visibly dirty and should have been cleaned the prior day. Of the 99 tasks that staff were directed to complete between August 1, 2014, and August 26, 2014, there were 48 tasks not signed as completed. [s. 72. (7) (c)]

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 there is an organized food production system in the home that provides for preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #10: 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:
1. Communication of the seven-day and daily menus to residents. 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. 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,
(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 the home has a dining and snack service that includes communication of the seven-day and daily menus to residents.

On August 7, 2014, the Silverthorne Way home area did not have the seven-day menu cycle posted in the home area. The home's Displaying the Menu policy, FN-0302-00 revised May 1, 2012, indicated that the standard week at a glance menu

was to be posted at the beginning of each week on each of the resident units. An interview with a Nutrition Manager revealed that the seven-day menu was communicated to residents through a posting near the second floor elevators and that the menu was posted outside of the home area's doors and was not accessible to the residents residing on Silverthorne Way. [s. 73. (1) 1.]

2. The licensee failed to ensure that the home has a dining and snack service that includes serving food and fluids at a temperature that is both safe and palatable to the residents.

On August 27, 2014, during the breakfast meal, room service trays were observed to sit on the counter for approximately 20 minutes before being delivered to the residents in their rooms. Interview with resident 57 revealed that the poached egg was very cold when he/she received it and he/she told the inspector that it would not be eaten. Resident 57 told the inspector that every time the eggs are offered, they are too cold to eat. [s. 73. (1) 6.]

3. During a lunch meal observation on August 14, 2014, a FSW was observed to plate a portion of egg bake for a resident after the egg bake had been holding in the steam table for over 50 minutes. The inspector requested the temperature of the food be taken, and the FSW reported the temperature to be 122 degrees Fahrenheit. The FSW indicated the food was not an appropriate temperature and reheated it in the microwave prior to serving to the resident. The home's Food Preparation and Service policy, FN-0207-00 reviewed September 1, 2013, indicated that hot held foods are to be served at a temperature of at least 140 degrees Fahrenheit. [s. 73. (1) 6.]

4. The licensee failed to ensure that the home's dining and snack service includes course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During a lunch observation on August 7, 2014, residents 10, 64, 65, and 66 were provided entrees prior to the completion of their soup. None of the residents were observed to indicate this as a preference. An interview with the nutrition manager confirmed that the plans of care for the identified residents did not direct staff to provide the residents with multiple courses at one time and that each of the residents should have been provided course by course meal service. [s. 73. (1) 8.]

5. The licensee failed to ensure that proper techniques to assist residents with eating,

including safe positioning of residents who require assistance.

During a lunch observation on August 7, 2014, resident 68 was observed to be receiving feeding assistance from an identified staff member. Observation and interview with the staff member confirmed that a tablespoon was used to assist the resident. The Total Assistance at Mealtime policy NU-0508-01, revised December 1, 2010, directs staff to offer food in bite-size portions to residents using a teaspoon. An interview with a nutrition manager confirmed that a long handled teaspoon should be used when providing feeding assistance to residents. [s. 73. (1) 10.]

6. The licensee failed to ensure that 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.

Interview with the PSW revealed that resident 55 required feeding assistance from staff. On an identified date, during the breakfast meal, staff were observed to deliver breakfast to the resident at 9:30 a.m. and leave it sitting on the resident's bedside table. Hot cereal was observed to be sitting in a mug with only plastic wrap covering the top of the mug. The staff member left the room to attend to other residents. The staff member did not return to assist the resident with his/her meal for approximately seven minutes. [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 that the home has a dining and snack service that includes serving food and fluids at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #11: 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 name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(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)
(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)
(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 failed to ensure that copies of the public inspection reports from the past two years for the long-term care home are posted in the home.

On August 12, 2014, the inspector observed the following inspection reports were not posted in the home:

2013_168202_0056 from October 9, 2013
2013_102116_0025 from June 17, 2013
2012_102116_0042 from January 30, 2013
2013_102116_0001 from January 28, 2013
2012_102116_0045 from January 23, 2013
2012_108110_0030 from December 12, 2012
2012_108110_0029 from December 12, 2012

The absence of the reports was confirmed in an interview with the administrator. [s. 79. (3) (k)]

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 copies of the public inspection reports from the past two years for the long-term care home are posted in the home, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that procedures are developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

Review of the home's Misplaced or Unlabelled Personal Clothing policy, LS-0210-00, reviewed September 1, 2011, revealed that the home did not have a process for reporting of residents' lost clothing. Interviews with PSWs and registered nursing staff revealed that the home's practice was to search for the lost piece of clothing and if it was not found to call the building services supervisor (BSS) to report it missing. An interview with the BSS confirmed this practice, and revealed that there is no record kept of lost items. The BSS further revealed that she was unaware of how lost items are communicated to direct care staff. The BSS confirmed that the home did not have a process in place or procedures developed to report residents' lost clothing items. [s. 89. (1) (a) (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 procedures are developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Record review and staff interview indicated that on an identified date, a staff member received a complaint by the SDM for resident 42 that the resident was treated in a rough fashion. Record review and staff interview indicated that the investigation of alleged abuse was started on the identified date, but the police force was not notified until three days later. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 125. Monitored dosage system

Specifically failed to comply with the following:

s. 125. (2) The monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities. O. Reg. 79/10, s. 125 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the monitored dosage system promotes the ease and accuracy of the administration of drugs to residents and supports monitoring and drug verification activities.

Record review revealed resident 58 received liquid medication daily. Review of the resident's blood work completed in two identified months revealed the resident was not at a therapeutic blood level for the medication. The medication was administered by the nursing staff using a plastic measuring medication cup. The medication cup does not have a measurement line for the prescribed dose. There were no other measuring devices available for the nurses to accurately administer the liquid medication. Interview with a nurse manager confirmed that the medication cup was not providing an accurate dose as prescribed. [s. 125. (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 monitored dosage system promotes the ease and accuracy of the administration of drugs to residents and supports monitoring and drug verification activities, to be implemented voluntarily.

WN #15: 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 the home complies with manufacturer's instructions for the storage of the drugs.

The inspector observed the medication fridge on the third floor. The fridge contained two boxes of Lantus insulin frozen and a third box which was water logged. The fridge did not contain a thermometer. The manufacturer's instructions from Lantus Canada, stated that unopened Lantus cartridges should be stored in a refrigerator, between two and eight degrees Celsius and that Lantus should not be allowed to freeze. Interviews with the ADOC confirmed that the insulin was frozen and the home did not comply with the manufacturer's instructions for safe storage of drugs. [s. 129. (1) (a) (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 the home complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #16: 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 were taken to ensure the security of the drug supply including monthly audit of the daily counts sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered.

Record review of the combined monitored medication record with shift count for resident 49 revealed that on an identified date, the registered staff did not sign or indicate the amount of narcotic left in the medication quantity section. Interview with the nurse manager revealed that a formal monthly audit was not completed. She/he was not aware that the narcotic count and registered staff signatures were not completed on the identified date, until she/he was informed about missing narcotic medication seven days later. [s. 130. 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 that steps were taken to ensure the security of the drug supply including monthly audit of the daily counts sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #17: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber

Record review indicated that the physician ordered a medication to be given at lunch and dinner for resident 46. Record review and interview with the registered staff confirmed that the medication was given at 10:30 a.m. instead of 12:00 p.m. Interview with the ADOC confirmed that the medication should not have been given prior to 12:00 p.m. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug.

Record review indicated that a medication's dosage was changed on two identified dates, for resident 48. Record review revealed that the staff did not document resident's response and the effectiveness of the drug after the first change and prior to the second change. There was no documentation indicating what the resident's status was prior to, during, or after the change in the medication dosage. Interview with the registered staff and ADOC confirmed that there was no documentation of the resident's response and the effectiveness of the drug during that period of time. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drug, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training in skin and wound care has been provided to all direct care staff.

Record review of the 2013 education data base show that a large number of direct care staff did not receive training in skin and wound care. Interview with the ADOC confirmed that the education for skin and wound care has not been provided to all direct care staff. [s. 221. (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 training in skin and wound care has been provided to all direct care staff, to be implemented voluntarily.

WN #20: 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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that 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.

Interview with resident 18 revealed that two identified staff were abrupt and loud during provision of care. Resident stated that the two identified staff used loud voices, that are not gentle, that she/he feels anxious and sad. Staff interview revealed that the two identified staff members speak in an abrupt, loud and disrespectful manner when they are talking to resident 18 and other residents. The staff member further revealed that the tone of voice used is perceived as ordering the resident instead of offering services. [s. 3. (1) 1.]

2. Record review indicates that the SDM for resident 45 reported that on two identified dates, the privacy curtain to the roommate's bed was closed. She/he heard snoring behind the curtain and later saw an identified staff coming out of the room. Resident 45's roommate was away for the weekend. Staff interviews confirmed that the incident was investigated and the resident's privacy of their personal living quarters was not respected and that the identified staff was disciplined. [s. 3. (1) 1.]

3. The licensee failed to ensure that every resident has the right to have his or her participation in decision-making respected.

Interview with resident 18 revealed that her/his choice for bedtime is not respected. She/he indicated a preference to sit in her chair to watch the television during the evening and the staff were refusing to respect his/her preference. Resident stated that the staff told him/her that they have to put him/her in bed in order to complete their paper work. Staff interview confirmed the above and that the resident's participation in decision-making is not respected. [s. 3. (1) 9.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Interview with the SDM for resident 6 revealed that their room is cold during the summer time. Staff interview and sample temperature readings completed by the building services supervisor using the home's laser thermostat instrument revealed on August 18, 2014, the resident's room temperature was only 19 degrees Celsius. [s. 21.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, interventions and the resident's responses to interventions are documented.

Interview with an identified rehabilitation assistant (RA) revealed that a weekly breakfast activity was available for residents on the home's fourth floor and is well attended by resident 31 and other unidentified residents on the floor. Review of resident 31's activity attendance record did not reveal participation in this program. The RA confirmed that participation in this activity is not recorded. Interview with the acting resident services manager confirmed that participation in all activities within the recreation program should be recorded. [s. 30. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids labeled within 48 hours of admission and of acquiring, in the case of new items.

Resident 9 was observed using a silver walker which was not labeled. Staff interview with the PSW and registered nursing staff confirmed that the resident's personal walker was not labeled. [s. 37. (1) (a)]

WN #24: 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.

Record review of Residents' Council Follow-Up report and interview with Residents' Council President revealed that on August 7, 2014, a concern was raised regarding the accessibility of the call bell system in a resident's washroom. Residents' Council President confirmed on August 18, 2014, that the Residents' Council had not received a response in writing to this concern. Interviews with the Residents' Council president and the acting resident services manager revealed that the manager verbally told the president the response to the concern, however, no written response was provided to the president or to the Residents' Council. [s. 57. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and the resident's substitute decision-maker if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

A family of an anonymous resident revealed that they were not notified of the result of the abuse investigation upon the completion of the investigation by the licensee. Staff interview confirmed that the resident's SDM was not notified of the result immediately upon the completion of the abuse investigation. [s. 97. (2)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee failed to ensure that at least annually there is an evaluation done of the utilization of drugs kept in the emergency drug supply in order to determine the need for drugs.

Interview with the ADOC revealed that an annual evaluation of the utilization of drugs kept in the emergency drug supply in order to determine the need for drugs had not been completed for 2013. [s. 123. (c)]

WN #27: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

The meal serving area is divided into two areas. The servery area is a restricted area for entry. According to a posted sign, staff are required to wear hairnets before entering this area. On August 27, 2014, during the breakfast meal on the 4th floor north wing, several nursing staff members were observed to walk in and out of the restricted area and were not wearing protections or hair nets to cover their hair. This requirement to wear hairnets was confirmed by the nutrition manager. [s. 229. (4)]

Issued on this 23rd day of October, 2014

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

Joelle Taillefer

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAURA BROWN-HUESKEN (503), JOELLE TAILLEFER (211), SUSAN SQUIRES (109), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2014_312503_0018
Log No. / Registre no:	T-112-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 3, 2014
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	WESBURN MANOR 400 The West Mall, ETOBICOKE, ON, M9C-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Judy Watson

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To TORONTO LONG-TERM CARE HOMES AND SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_163109_0015, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following areas are addressed:
Skin assessments are completed by a member of the registered nursing staff, using the homes clinically appropriate assessment instrument that is specifically designed for skin and wound for resident 8 and 33 exhibiting altered skin integrity.
Reassessments are conducted at least weekly by a member of the registered nursing staff for resident 33 and 54 who are exhibiting altered skin integrity.

The compliance plan must identify short and long-term strategies to ensure the actions taken are monitored and evaluated.
Please submit the compliance plan to Susan.Squires@ontario.ca by October 24, 2014.

Grounds / Motifs :

1. Ontario Regulation 79/10 s. 50 (2) has been the subject of a previous compliance order to the licensee with a compliance date of May 30, 2014 (inspection #2014_163109_0015 from May 7, 2014).

The licensee has failed to ensure that each resident exhibiting altered skin integrity, received 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.

Record review and resident observation revealed resident 33 had altered skin integrity. The home used a specific weekly ulcer/wound assessment record which is to be completed for each wound. Record review and staff interviews indicated that the skin assessments were not completed using the home's skin assessment tool for an identified one moth period, after the doctor prescribed a treatment for the wound. This was confirmed by the ADOC. (109)

2. Resident 8 had two pressure ulcers. The home had an assessment tool which was to be completed for each wound on a weekly basis. Record review and staff interviews revealed that there were no skin assessments completed on the home's assessment tool for one of the pressure ulcer for six identified weeks. There are no skin assessments completed on the home's assessment tool for the other pressure ulcer for one identified week. This was confirmed by the ADOC. (109)

3. The licensee has failed to ensure that each resident who is exhibiting altered skin integrity, including wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Record review and resident observation revealed resident 33 had altered skin integrity. On an identified date, the resident had a surgical procedure for the wounds and a treatment was prescribed. Record review and staff interviews revealed that the resident did not receive weekly skin assessments by a member of the registered nursing staff for the wound from the identified date, when the treatment was ordered until one month later, when the treatment was discontinued. This was confirmed by the ADOC. (109)

4. Record review and resident observation revealed resident 33 had altered skin integrity. On an identified date, the resident had a surgical procedure for the wounds and a treatment was prescribed. Record review and staff interviews revealed that the resident did not receive weekly skin assessments by a member of the registered nursing staff for the wound from the identified date, when the treatment was ordered until one month later, when the treatment was discontinued. This was confirmed by the ADOC. (109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan outlining how the home will ensure the following policies are complied with:
- The home's Narcotic and Controlled Substances policy
- The home's Off-hours Medication Supply policy

Please submit plan to Susan.Squires@ontario.ca by October 24, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with.

Review of the home's policy titled Medications – Off-Hours Medication Supply, PH-0109-00 revised January 6, 2012, directed staff to count the off-hours medication supply on a bi-weekly basis by two registered staff.
There were two different Off-Hours Medication Supply Control Sheet observed and used interchangeably. Form #81-6361-10-05 included drugs that were not stocked in the off-hours medication supply. This form included Tylenol #3 which was no longer stocked. When used, the form required manual changes including striking out Tylenol #3 and adding in Tylenol #2.
The inspector observed the form for July 24, 2014 and noted that the Tylenol #3 had not been manually changed to read Tylenol #2. The registered nursing staff and NM both signed off as counting Tylenol #3. Interview with the registered nursing staff confirmed that it was Tylenol #2 and the manual change to the

record did not occur.
The inspector observed and record review revealed the registered nursing staff were not counting the off-hours medication on a bi-weekly basis. The off-hour medication supply control sheets were reviewed from March 26, 2014 to August 22, 2014. The bi-weekly count was not completed for the following periods:
- May 24 and June 10, 2014,
- June 10 and July 7, 2014,
- July 24 and August 22, 2014.
Staff interviews with the registered nursing staff and the ADOC confirmed that the home's policy for counting the off-hours medication supply did not occur on a bi-weekly basis and that the correct form was not consistently being used. (557)

2. The home's policy titled Narcotic and Controlled Substances PH-0106-00, published January 6, 2012, indicated that two nurses, one from the outgoing shift and one from the oncoming shift, will count narcotics and controlled substances utilizing Narcotic and Controlled Substances Record. The policy directs staff to record the declining balance on the narcotic record and maintain this record in front of the medication administration record (MAR) for the individual resident. Interviews with identified registered staff revealed that a narcotic blister pack containing 25 Percocet tablets was missing on an identified date. The identified registered staff members indicated that the narcotic blister pack was signed for but not always counted with two registered staff over a one month period. The missing blister pack was accounted for two days prior. During the three shift changes on an identified date, and the 7:00 a.m. shift change the following day, the outgoing and incoming registered staff members signed for the blister pack but reported they did not count. A total of four registered staff reported that they did not complete the count or did not complete the count with a second registered staff member present. At the 3:00p.m. shift change on the day that the 25 Percocet tablets were noted missing the outgoing registered staff signed for the blister pack but did not count. The incoming registered staff completed the count independently and noted the blister pack missing and reported this to the home's management. (211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Laura Brown-Huesken

Service Area Office /
Bureau régional de services : Toronto Service Area Office