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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2016_543561_0028	033893-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WEST OAK VILLAGE
2370 THIRD LINE OAKVILLE ON L6M 4E2

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

DARIA TRZOS (561), CATHIE ROBITAILLE (536), NATASHA JONES (591), THERESA MCMILLAN (526)

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): December 12, 13, 14, 15, 16, 19, 20, 21, and 22, 2016

The following concurrent inspections were completed with the Resident Quality Inspection (RQI):
Critical Incident Inspections:
018473-15 - responsive behaviours
015024-16 - resident to resident altercation
023872-16 - staff to multiple residents alleged abuse
027172-16 - staff to resident alleged abuse

Complaint Inspection:
010946-16 - care related issues
013832-16 - admission refusal

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Environmental Services Manager (ESM), Resident Services Coordinator, Physiotherapist, Recreation Therapist, Behavioural Supports Ontario (BSO), Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, Family Council Representative, Resident's Council Representative, families and residents.

During the course of the inspection, the inspectors toured the home, observed the provision of care, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **12 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date in 2016, a Critical Incident System (CIS) report was submitted to the Director about an alleged staff (PSW#114) to resident abuse. Resident #023 reported the alleged abuse to the home. Resident was upset about the PSW #114's actions.

Resident #023 was interviewed during this inspection, and was able to recall the incident and confirmed the actions of PSW #114. During this interview resident indicated that they were upset about the incident.

The home had commenced an investigation, police was contacted, and family of the resident was informed. The incident was confirmed by the home.

During the inspection, it was identified that there were other instances where the same PSW was involved in alleged incidents of abuse towards other residents, but could not be confirmed by the home.

Long Term Care Homes (LTCH) Inspector was not able to contact PSW #114.

A review of the home's policy called "Resident Non- Abuse – Ontario", policy number LP-C-20-ON, revised September 2014, stated the any form of abuse by any person interacting with residents, or neglect or residents by staff will not be tolerated.

The licensee failed to ensure that resident #023 was protected from abuse. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's "Resident Non Abuse-Ontario" policy, policy number LP-C-20-ON, revised September 2014, stated that "any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care.
1. Improper or incompetent treatment or care of resident that resulted in harm or a risk of harm to the resident
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident".

During this inspection, it was identified that PSW #114 was involved in incidents of alleged abuse that were not reported to the Director in 2015 and 2016. Health record review and investigation notes indicated that these incidents could not be confirmed by the home.

The ADOC and DOC confirmed that none of these alleged incidents of abuse were reported to the Director. [s. 20. (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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

On December 16, 2016, at approximately 0900 hours, during conversation with LTC Inspector #526, the Environmental Services Manager (ESM) mentioned that two circulating air exchangers were noted to be blowing cold air on December 15, 2016. ESM stated that they called Naylor, the heating company, and they stated to turn off the air circulation for unit #1 (feeds the east wing, Harbour and Bronte) and unit #4 (feeds William and Chalmers). The ESM turned them off at 1645 hours and then left the home. The ESM informed the LTC Inspectors #526 and #561 that there was one room in the building that was 12 degrees Celsius and stated that he contacted Naylor about the heating issue.

LTCH Inspectors #526 and #561 immediately went up to the Harbour and Bronte home areas and noticed that it was cold. On the Harbour home area, four residents were observed sitting in their rooms, no electric heaters were observed in those rooms. On the Bronte home area four residents, #009, #010, #011, #030, stated that they were cold and resident #030 also stated that it was cold at night.
The ESM had conducted temperature readings on the Harbour home area of few rooms while inspectors were present with a thermometer and the temperature readings showed that the temperature in most of the rooms was below 22 degrees Celsius.

Interviewed registered staff #107 about the home's policy and contingency plan when the home area is found to be cold. They stated that this morning when they arrived at 0700 hours, they felt that the home was cold and directed staff to get residents up and into the dining room as the temperature in the dining room was warmer that in residents' rooms. ESM was notified of the drop in temperatures in the morning by registered staff.

When asked about the home's Emergency and Contingency Plan, registered staff #107 stated that their role was to assess the residents, get them to a warm location and then contact the ESM to inform them of the lowered temperatures in the home area.
The registered staff stated that night shift should have contacted the ESM during the night if they felt that the home area was cold and that this is what they would have done in this case.

The ESM provided a log of the temperatures from unit #4 that supply heating to Chalmers and William home areas that were taken at night and they indicated that between 0100 hours and 0700 hours on December 16, 2016, the temperatures varied between 7.6 and 8.6 degrees Celsius.
ESM confirmed that staff in the home should have called to inform them that care areas were cold. The vendor hired by the home to monitor temperatures also had not notified them that temperatures in home areas had dipped.

The licensee failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius. [s. 21.]

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 temperature in the home is maintained at a minimum of 22 degrees Celsius, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident’s plan of care only if all of the following were satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD was reasonable, in light of the resident’s physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD was approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provided for everything required under subsection (5). 2007, c. 8, s. 33 (4).

During this inspection, resident #032 was observed in a wheelchair and had a device applied. Resident voiced a concern to the LTCH Inspector that the device was too tight and resident was having pain. Registered staff #119 was informed and removed the device to observe resident’s skin. The health care records were reviewed and did not identify the use of the device as a Personal Assistance Services Device (PASD) or restraint. The doctor's order was not obtained, the use of the device was not consented by the SDM and there was no monitoring of the application of the device completed.

ADOC #121 who was the lead for the restraints program confirmed that the use of the device was considered a PASD with restraining qualities and the home did not complete all the requirements for the PASD as required by the legislation. [s. 33. (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 use of a PASD under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following were satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD was approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provided for everything required under subsection (5). 2007, c. 8, s. 33 (4), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

In an interview, resident #028's family member stated there was an incident on an identified date in 2016, where they found the resident unsupervised in a bathroom secured to a device. PSW #120 was interviewed and confirmed the incident.

A review of four related policies confirmed that the policies were not complied with.

In an interview, the DOC confirmed resident #028 should not have been left unattended and secured to the device and further confirmed staff did not use safe transferring techniques when toileting the resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

During interview, resident #020’s family member complained that the resident was not assessed and alternatives were not tried prior to the resident being transferred to a different unit. They expressed not being included in the decision regarding the resident’s transfer. The home’s Resident Care Coordinator confirmed this during interview.

According to their health record, when resident #020 was admitted to the home on an identified date, they had history of responsive behaviours. Review of electronic and paper health records, and interview with the home’s Behaviour Support Ontario (BSO) RPN #112, revealed that the resident's behaiours could not be easily altered. Their plan of care included a number of interventions to address these behaviours.

During interview, the home’s BSO staff stated that the resident was assessed on admission to the home. The BSO RPN confirmed that they were not actively involved in care or the decision regarding the resident’s transfer to the different unit. They also confirmed that they were not involved in the implementation of the plan of care and evaluation of the implementation of the plan of care when resident's behaviours changed prior to the transfer to the different unit.

Review of the home's related policy directed staff to complete a comprehensive assessment using a specific tool to address changes in behaviours. During interview, the Director of Care confirmed that assessments, reassessments of resident #020’s behaviour or alternative interventions were not developed to respond to their needs prior to the transfer. (526) [s. 53. (4) (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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the home's policy to manage odours: "Quality Management Urine Odour Audit", policy number ES C-25-15, last reviewed January 21, 2015, indicated that staff actions in the event of a lingering odour were to observe, look for root cause, deal with the root cause, and monitor.

During observations on December 16, 19 and 22, 2016, it was noted that one room on the third floor had a lingering urine odour. The interview with housekeeping staff #109 indicated that if there is a spill on the carpet, the staff will try to clean right away, call housekeeping and then the deep clean will be contacted as well. The deep clean is done by maintenance and they try to come as quickly as possible since if they wait, the spill stain will set and it will be difficult to remove the smell.

The interview with PSW #124 indicated that the identified room has had odours for a while. The staff tried to clean the carpet many times.

Interview with the ESM on December 21, 2016, indicated that they were not aware of the strong odour in the identified room. The procedure in the home was to let maintenance know about strong odours that do not disappear. ESM stated that if the odour could not be removed the home can remove the carpet and place flooring in resident's room.

The licensee has failed to ensure that procedures were implemented to address the lingering odour in the identified room. [s. 87. (2) (d)]

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 implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #8: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

During interview, resident #020's family member complained that the resident was not assessed and alternatives were not tried prior to the resident being transferred to a different unit. They expressed not being included in the decision regarding the resident's transfer.

Review of resident #020's health record revealed that they were unable to make care decisions for themselves. Progress notes revealed that the family member had not been contacted or included in the development of the plan of care relating to the decision to transfer the resident to a different unit and the family member was upset.

During interview, the home's Resident Care Coordinator confirmed that resident #020's family member was not informed and was not given an opportunity to be present for the transfer or to be involved in the development of the resident's plan of care regarding the decision to transfer them.

During interview, the DOC confirmed that resident #020's family member was not provided the opportunity to participate fully in the development and implementation of their plan of care specifically regarding the resident's transfer. (526) [s. 6. (5)]

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

In an interview, resident #028's family member stated that the resident could not communicate in English.
In an interview, with resident #028 with the assistance of an independent interpreter, it was confirmed that the resident could communicate effectively in their native language.

A review of resident #028's most recent written plan of care, indicated the resident had an intervention in place to facilitate communication between the resident and staff. Observations during inspection confirmed that the intervention was not implemented.

Interviews with PSW #120 and registered staff #119, and interviews with recreation staff #122 and the Program Manager, confirmed the intervention was not implemented as per their written plan of care.

In an interview, the DOC confirmed the intervention to facilitate communication was not implemented as per the written plan of care. [s. 6. (7)]

WN #9: 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 has failed to ensure that the Emergency Procedures – Priority Code – Loss of Heat policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Regulation 21 of the Long Term Care Homes Act, 2007 states that every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius (C).

The home's policy called "Emergency Procedures - Priority Code - Heat Loss", policy number EPM-J-06, dated March 16, 2010, stated that the licensee will have a plan in place and be prepared to deal with a loss of heat in the building below 20 degrees Celsius (C).
The ESM confirmed that the policy did not meet legislative requirements since the policy directed staff to implement a plan if the home area fell below 20 C rather than 22 C. [s. 8. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee failed to ensure if the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, (a) the ground or grounds on which the licensee is withholding approval; (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justify the decision to withhold approval; and (d) contact information for the Director.

In an interview, complainant #027 stated they received an admission rejection letter from the home based on specific grounds.
A review of documentation provided by the home identified that the home was unable to accommodate the resident's needs. The application was declined for the home's wait list, and the instruction was given to contact the Community Care Access Centre (CCAC) or the Ministry of Health and Long Term Care (MOHLTC) action line to contest the decision.

In an interview, the Program Manager (former RCC) confirmed that they were responsible for reviewing admission applications, and issued the above mentioned admission refusal letter to complainant #027. The Program Manager confirmed that the complainant's application for admission was refused on specific grounds.

The Program Manager confirmed that a detailed explanation of the supporting facts and an explanation of how the supporting facts justified the decision to withhold approval were not included in the written notice to complainant #027. [s. 44. (9)]

WN #11: 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 has failed to ensure that drugs complied with the manufacturer's instructions.

On December 13, 2016, following the medication pass the medication cart on Chalmer House home area was checked for dated eye drops. After identifying eye drops had not been dated when they had been opened, all medication carts in the home were checked for eye drops to ensure they were dated as to when they were opened, and when they were to be discarded 30 days later as per the home's pharmacy directive. The LTCH Inspector noted the following:
The inspector noted the following:

i) Chalmer House – two bottles of eye drops were not dated
ii) Harbor House - three bottles of eye drops were not dated
iii) Williams House – three tubes of eye ointments were not dated

The Associate Director of Care confirmed that the pharmacy directive is all eye drops and eye ointments will be discarded thirty days after they are opened. [s. 129. (1) (a)]

WN #12: 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 participated in the implementation of the infection prevention and control program.

Review of the home's "Cleaning/Disinfecting/Sterilizing Resident Equipment" policy, policy number IPC-C-10, last reviewed May 2014, and the home's "Bath and Shower Guidelines" policy, policy number CARE14-010.02, effective as of August 31, 2016, and interview with ADOC # 100, indicated that the home's Infection Prevention and Control Program expected that staff would ensure that resident care equipment such as nail clippers, combs, brushes, razors, toothbrushes, and deodorant were disinfected according to the home's schedule, and were not shared between residents.

During initial tour of the home on December 12, 2016, between 0900 and 1000 hours, an LTCH Inspector observed the following unlabelled, used resident care items stored on counters and in cabinets of spa and/or shower rooms on four of five resident care areas in the home: nail clippers, combs, hair brushes, razors, deodorant and a toothbrush. During observation on December 14, 2016, used, unlabelled nail clippers, combs, hair brushes, razors, were found stored in a cart/cabinet on Chalmers home area shower and spa rooms. PSW #103 confirmed that combs, brushes, and nail clippers were stored in the spa and shower rooms, and that they washed and reused them for multiple residents.

During interview ADOC #100 confirmed that staff had not followed the home's Infection Prevention and Control Program since the resident personal care items should be labelled, stored at their bed side and not shared by other residents. [s. 229. (4)]

Issued on this 10th day of February, 2017

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

Original report signed by the inspector.