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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2018	2018_718604_0009	008092-18	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

SHIHANA RUMZI (604), ADELFA ROBLES (723), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 1, 2, 3, 6, 7, 8, 9, and 10, 2018.

During the course of the home's Resident Quality Inspection (RQI) the inspectors reviewed intake log #025630-17 (A1), Inspection Report #2017_530672_0015, Order #001, served January 17, 2018.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Environmental Services Manager (ESM), Physiotherapist (PT), Skin and Wound Coordinator (SWC), Infection Lead (IL), Education Coordinator/Nursing Support (ECNS), Dietary Aide (DA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), Substitute Decision Makers (SDMs), Presidents of Residents' and Family Council.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_530673_0015	723

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Resident #003 triggered through stage one of the Resident Quality Inspection (RQI) for choices lacking through a resident interview. During the resident interview the resident stated that they do not receive the identified care.

A review of resident #003's written plan of care and the current Kardex was reviewed. Under a focus it indicated resident required assistance and the interventions it stated provide physical help with identified care with one staff assistance; two staff required for transfers. The written plan of care and the Kardex did not identify the days or times of the resident's identified care.

On an identified home area the Inspector reviewed a list with identified care to be provided to the residents with an identified date the list was updated and the list did not consist of resident #003's identified care dates and times.

Interviews were carried out with Personal Care Provider (PCP) #119 and Registered Practical Nurse (RPN) #108. The PCP and RPN indicated if they need information related to resident care routines they are able to refer to the written plan of care and the Kardex binder located at the nursing station, the Point of Care (POC), and the identified care list was located also in an identified area of the home. The RPN stated the identified care list is updated and posted which the PCP staff refer to each day to see which residents care needs on each shift. The PCP and RPN reviewed the written plan of care,

Kardex, and identified care list with Inspector #604 and acknowledged that neither document had information as to when resident #003 is to receive their care. The PCP and RPN stated the information needs to be in the Kardex, written plan of care, and the identified list so that there is clear direction to staff as to when the care to be provided.

An interview was carried out with the Director of Care (DOC) who indicated that staff are to refer to the identified care list or the written plan of care related to residents care needs. The DOC reviewed resident #003's identified care list and written plan of care and indicated that there was no information related to which days the resident is to be provided care.

2. Resident #004 triggered through stage one of the RQI for the use of specified devices through resident observation. During stage one it was observed that the specified devices was being utilized.

Observations were carried out throughout the day on identified days, for resident #004's specified devices by Inspector #604 and #723. During the observations it was noted that when the resident was in an identified location of the home the specified devices were in place.

A review of resident #004's written plan of care indicated the resident was at high risk for falls and interventions were identified to be in place when the resident was is in bed. The written plan of care further indicated that the resident required specified devices and the intervention indicated a specified device should be in place and secured while resident was in an identified location of the home. The written plan of care did not indicate the use of two specified devices when the resident was in an identified location of the home.

Interviews were carried out with RPN #104 and PCP #113 and interviews were carried out also on the alternate shifts with RPN #111 and PCP #125. The RPN's and PCP's indicated that if they need care directions related to resident's care needs they refer to the written plan of care and Kardex copies which was located on the unit at the nursing station and or POC. The RPN's and PCP's stated that if a resident was utilizing specified devices or it would be documented in the residents written plan of care and kardex. The RPN's and PCP's stated resident #004 was a one person physical transfer in and out of bed and also into their wheel chair. The staff further indicated that when resident was in an identified location of the home the specified devices were to be utilized for the residents safety. The RPN's and PCP's reviewed the resident #004's written plan of care and kardex and acknowledged that the documents indicated the use of one specified

device and did not provide clear direction as to the use of the two specified devices when the resident was in an identified location of the home.

An interview was carried out with the DOC who indicated that if staff need direction related to resident's ADL or care needs the staff was expected to refer to the written plan of care and Kardex and copies are located on the unit in the nursing station and the staff could also refer to POC. The DOC reviewed resident #004's written plan of care, the kardex, and indicated that the there was no clear direction as to the use of the two specified devices for resident #004.

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

Resident #007 triggered through stage one of the RQI for alteration in skin integrity through census record review. Stage one notes indicated resident #007 had an identified alteration in skin integrity in an identified location.

A review was carried out of resident #007's Electronic Medication Administration Record (EMAR) and physician order for the identified alteration in skin integrity directed staff to provide identified care to the resident on identified dates and as needed (PRN). Monitor for further breakdown, monitor wheelchair cushion. Reposition and turning schedule one time a day.

On an identified date and time Inspector #604 and #723, carried out a dressing change observation for resident #007's dressing change with the Skin and Wound Coordinator (SWC) #117. The SWC had assistance from an RPN who assisted to turn and reposition resident #007. The SWC removed the dressing with an identified dated and the RPN showed the Inspectors the dressing and an identified area on the dressing. Inspector #604 and #723 observed characteristics of the dressing which was removed. The SWC stated that an identified treatment had not been applied during the previous dressing change as the dressing would have a different appearance. The SWC further indicated that care had not been provided to resident #007's alteration in skin integrity as indicated.

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 sets out clear directions to staff and others who provide direct care to the resident
-that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

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 :

The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 136 (1) a, b, and d (i), Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of, (a) all expired drugs; (b) all drugs with illegible labels; (d) a resident’s drugs where, (i) the prescriber attending the resident orders that the use of the drug be discontinued.

A review of Classic Care Pharmacy's policy titled "Medication Disposal" policy #5.8, with a revised date of July 2014, directed the staff under policy for medication destruction - LTCH's that with the exception of controlled substances, medications designated for disposal are destroyed at the home by a team of individuals comprised of a registered staff member and another staff member, both of whom are appointed by the Director of Care. In most cases, medications designated for disposal are comprised of expired drugs, drugs with illegible labels, drugs in containers that do not meet the necessary marking requirement as outlined in the DPRA, drugs that were held or refused, discontinued drugs, drugs for a deceased resident, or drugs for a discharged resident that were not sent with the resident.

During stage one of the RQI, Inspector #653 had conducted an observation on an identified date and time for resident #012 in an identified location of the home. The Inspector observed identified medication to be stored inappropriately after the identified period of time for the use of the medication had passed.

A review of resident #012's “Prescriber Order” form revealed that the attending physician had identified medications for the resident to be used for an identified period of time.

Interviews were held with RPN #110 and the DOC. The RPN and DOC acknowledged the above mentioned observations and indicated that resident #012's identified medications should have been disposed of after it was no longer required to be used by the resident. The RPN and DOC acknowledged that in this case, the policy on medication disposal had not been complied with.

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 any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee had failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

On an identified date Inspector #604 carried out the initial tour of the home. At an identified home area an identified door was observed to be unlocked.

An interview was conducted with RPN #108 who acknowledged that the identified door was unlocked and stated they were unsure if the identified door was to be left unlocked or locked. The Inspector and the RPN entered the room and found identified items to be stored in the room.

An interview was carried out with the DOC who stated that if staff use the identified door it is to be locked after use. The DOC was informed by Inspector #604's observations above and the DOC stated the identified door is to be locked at all times as the identified

items stored in the room presented a risk for residents.

2. During the initial tour of the home on an identified date and home area an identified door was found unlocked and slightly open. Inspector #653 entered the identified door and no staff were present and observed a large container of an identified substance to be sitting on the counter. At an identified time, PCP #100 brought a resident into the identified area and indicated to the Inspector that the door was unlocked, but was supposed to be locked when unsupervised.

At an identified time, the Inspector entered an identified location of the home, and headed to another identified area of the home and noticed an identified area door was unlocked. A sign was posted on the identified door directing staff to keep the identified door locked at all times. The Inspector entered the identified area and no staff was present inside and observed an identified object to be stored inappropriately. Another identified door was closed but unlocked, with a sign posted on the identified door indicating "to be kept closed". The Inspector entered the identified area and Dietary Aide (DA) #102 was inside. When asked by the Inspector about the identified doors the DA stated that the identified door was to be kept locked at all times, and second identified door was to be kept closed at all times.

An interview with RPN #103 who was in-charge of an identified home area, indicated that the identified doors were to be locked when unattended by staff.

An interview with the DOC acknowledged the above mentioned observations and indicated that the two identified doors were supposed to be locked when unsupervised by staff.

3. During the initial tour of the home on conducted on an identified date and home area an identified door was found to be unlocked when the door was pushed and Inspector #653 was able to enter the room. The Inspector observed two compartments on the wall, both compartments where accessible by turning the handle/lock mechanism down. The bottom compartment consisted of a large container of unlabelled pink fluid.

Interviews were conducted with RPN #104 and Environment Services Supervisor (ESS) #105 and stated that the identified door was considered as a non-residential area and only staff members utilized the identified area and the door is to be locked at all times when not in use

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas where equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

The licensee had failed to ensure that when bedrails are used the resident is assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #004 triggered through stage one of the RQI for an identified device through resident observation. During stage one it was observed that an identified device was being utilized by the resident.

On an identified date observations were carried out throughout the day for resident #004's identified device by Inspector #604 and #723. During the observations it was noted that when the resident was in an identified area of the home, the identified device being utilized and a second identified device was also being utilized at the same time.

Interviews were carried out on identified shift on an identified date with RPN #104 and #111. The RPN's indicated resident #004 utilized an identified device when in an identified area of the home due to falls and they were unaware if an assessment had being completed for resident #004.

An interview was carried out with the DOC who indicated that if a resident uses an identified device assessments are to be completed quarterly and annually. The DOC stated a multidisciplinary approach is taken by the home and there is also an identified assessment that needs to be completed annually and quarterly. Inspector #604 and the DOC reviewed resident #004's identified assessment completed on the resident's admission with an identified locked date and the DOC acknowledged that no other subsequent identified assessment was completed and the identified assessment carried out on admission did not show evidence that the identified device assessment was completed assessing the risk of the device being utilized by the resident.

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 bed rails are used the resident was assessed and their bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee had failed to ensure that when a resident is restrained by a physical device it was included in the plan of care.

Resident #004 triggered through stage one of the RQI for an identified device through resident observation. During stage one it was observed that an identified device was being utilized by the resident.

On an identified date observations were carried out throughout the day for resident #004’s identified device by Inspector #604 and #723. During the observations it was noted that when the resident was in an identified area of the home, the identified device being utilized and a second identified device was also being utilized at the same time.

A review of resident #004’s written plan of care, indicated the resident was at high risk for falls and interventions were identified. Another focus under an identified device, and the intervention indicated identified care to be provided to the resident. The written plan of care did not indicate the use of two identified devices when the resident was in an identified location of the home, only the use of one of the identified devices.

A review of resident #004’s kardex located at the nursing station was reviewed and did not indicate the use of two identified devices for the resident.

Interviews were carried out with RPN #104, PCP #113, RPN #111, and PCP #125. The RPN’s and PCP’s stated that if a resident used a restraint by a physical device it would be documented in the residents written plan of care and the kardex which was located at the nursing station. The RPN’s and PCP’s stated resident #004 was a one person physical transfer in and out of bed and when the resident was in an identified area of the home the resident utilized one identified device.

An interview was carried out with the DOC who indicated that the identified devices acted as a restraint when the resident was in an identified area of the home and the use of a two identified devices was not identified in either document or included in the resident's plan of care.

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 was restraint by a physical device it was included in the plan of care, to be implemented voluntarily.

WN #6: 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 :

The licensee had failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

During stage one of the RQI, Inspector #653 conducted an observation of resident #012 in an identified location of the home on an identified time and date. The Inspector observed an identified medication to be stored in an identified location with an identified period of time for the use of the medication. The identified medication was stored inappropriately.

Interviews were held with RPN #110 and the DOC and they acknowledged that resident #012's identified medication was not stored in an area or a medication cart that was secure and locked.

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 were stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #7: 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 :

The licensee had failed to ensure that the staff participated in the implementation of the infection prevention and control program.

On an identified date and time Inspector #653 conducted the initial tour of the home and on an identified location the Inspector observed an identified door to consist of an identified sign to be posted on the identified door and did not consist of any identified equipment.

An interview was carried out with RPN #124 who indicated that resident #011 had an identified diagnosis and was kept in an identified location of the home.

An interview with Infection Control Lead (ICL) #117 who stated that resident #011 had an identified health condition and was to have identified equipment as per the home's policy. The ICL acknowledged that during the initial tour of the home, the staff did not participate in the implementation of the infection prevention and control program to ensure that the proper identified equipment was available.

2. On an identified date and time Inspector #604 conducted the initial tour of the home. In an identified location of the home and the Inspector observed an identified location of the home consisted of identified equipment and did not have an identified signage posted prior when entering the identified location of the home.

Interviews were conducted with RPN #108 and PCP #109 who stated resident #011 had an identified health condition and was to have an identified sign posted on an identified location of the home to indicate the proper identified equipment to be utilized. The RPN and PCP acknowledged that the identified location of the home did not have the required identified sign posted.

An interview was carried out with the ICL #117 who indicated that when a resident was identified with an identified health condition the home is to ensure that the identified location of the home consisted of required identified signs to be posted. The ICL was informed of the above observations and interviews and the ICL acknowledged that when Inspector #604 carried out their observation for an identified location of the home they did not observe an identified signage in an identified location of the home.

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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee had failed to ensure that every resident has the right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date and time Inspector #604 was on an identified are of the home and observed a medication cart placed across the nursing station with the EMAR screen open to resident #001's medication administration record. There was a nurse sitting inside the nursing station behind the counter on the computer.

Interviews were carried out with RPN #108 and the DOC who stated the home's expectation was that if the EMAR screen is not in use it is to be locked or closed to protect residents Personal Health Information (PHI). The RPN and the DOC acknowledged that when the EMAR screen is left open to resident #001's medication profile and that the residents PHI was not protected.

Issued on this 3rd day of October, 2018

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

Original report signed by the inspector.