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
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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
Sep 15, 2015	2015_268604_0011	T-1674-15	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

SHIHANA RUMZI (604), JANET GROUX (606), NITAL SHETH (500)

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): July 2, 3, 6, 7, 8, 9, 10, 13, and 14, 2015.

During the course of the inspection the following critical incidents: T-1338-14, T-15963-15, T-1352-14, complaint: T-002462-15, and follow-up order:T-1541-14.

During the course of the inspection, the inspector(s) spoke with Interim Administrator, Interim Director of Care (DOC), Associate Director of Nursing (ADON), Environmental Services Manager (ESM), Registered Staff (RN), Registered Practical Nursing (RPN), Personal Support Workers (PSW), Dietary Manager, Skin and Wound Care Lead/Coordinator, Able Health Home Care Services homes representatives, Physiotherapy (PT), Resident Council President, Family Council Representative, Infection Prevention and Control (IPAC) Lead, Housekeeper, and Resident, Family, and Friends.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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

14 WN(s)
8 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
O.Reg 79/10 s. 241. (12)	CO #001	2014_163109_0031	500

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

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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 :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 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 #016, resident revealed an identified staff member speaks to the resident in an inappropriate tone during care. Resident stated the identified staff member was asked to refrain from using that tone with the resident. The resident confirmed the identified staff member continues to use an inappropriate tone during care.

The identified staff member confirmed they use and inappropriate tone when providing

care to resident #016.

An interview with an identified manager revealed the home was unaware of the incident. He/She confirmed that the tone the staff member was using with resident #016 did not uphold the residents' right to be treated with courtesy and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident has the right to 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.

On July 10, 2015, at 9:30 a.m., the inspector observed an unattended medication cart stored on an identified unit outside a resident room. The Electronic Medication Administration Record (E-MAR) screen was left open to an identified resident's personal medication administration record, which was visible to the public.

On July 13, 2015, at 12:31 p.m., the inspector observed an unattended medication cart to be stored on an identified unit outside the dining room. The E-MAR screen was left open to an identified resident's personal medication administration record, which was visible to the public.

Interviews with identified staff members confirmed the E-MAR screens was unlocked, personal medication administration record of the identified residents were visible to the public, and personal health information was not protected.

The home follows the MediSystem Policy/Hand book for medication administration procedures. Medication and Treatment Administration Record hand book states under "Administration Screen section e" on page 42: Once all medication has been clicked (updated medication will be highlighted in yellow) Lock Screen for privacy before walking over to resident to administer the medication.

An interview with an identified manager and staff confirmed the identified residents personal health information was not protected from the public [s. 3. (1) 11. 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 following rights of residents are fully respected and promoted:
- 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;

- 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,, to be implemented voluntarily.

WN #2: 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. (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 care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #017's plan of care on an identified date revealed the resident is at risk of falling related to health conditions and medication use.

The care directed staff members to monitor resident #017 for a specified duration of time during the course of the shift.

Interviews held with identified staff members confirmed that the resident was being monitored for a specified duration of time different from the plan of care.

Interview with an identified manager confirmed resident #017 did not receive care set out in the 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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is and complied with.

Interview with resident #011 revealed the resident performs a specified treatment independently.

The home's policy "Self Administration of Medications" INDEX I.D:RCS F-40 procedure dated July 15, 2013, indicates in #2: The medication must be specified on the Physician's Order and on the electronic Medication Administration Record (E-MAR) as 'may leave at bedside for self-administration in a secured container.

A review of the resident's physician's orders failed to reveal an order for resident #011 to self administer the treatment. A review of the ETAR showed the RPN staff signed off for the treatments as being completed.

An interview with the home’s identified staff indicated to the inspector the resident and nurses are carrying out the treatment and that there was no physician's order for the resident #011 to self-administer the treatment.

An interview with the Interim DOC confirmed there was no order directing the resident #011 to administer his/her own treatment and home's policy was not followed.

2. On a specified date and time, on an identified floor the inspector observed two unlabelled medication cups containing medications sitting on top of the medication cart.

A review of the home policy "Medication System-Carded System" - Index Number 04-01-20 last reviewed June 23, 2014 indicates all medications should remain in the multi-dose strip provided by the pharmacy until administered to the resident.

Interview with an identified nursing staff revealed that the medications were refused by resident #020 and #021 and confirmed they should be labelled with the residents' names.

Interview with the interim DOC confirmed that the home's policy is to label the medications with the residents' names.

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 instituted or otherwise put in place is:
(a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
(b) complied with, to be implemented voluntarily.

WN #4: 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 :

1. The licensee has failed to ensure that 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.

Observation on July 2, 2015, during the initial tour of a specified floor, revealed a TV Lounge which consisted of a storage area containing two g-feeds pumps on the poles, 12 wheel chairs, and a Hoyer lift. The storage area was separated from the TV lounge with a dark blue plastic shower curtain and was accessible to resident sitting in the TV lounge.

On July 9, 2015, at 1:40 p.m., the inspector observed resident #034 was in the storage area with no staff member present. The inspector directed the resident to come out of the storage area.

An interview with the Environmental Services Manager (ESM)#142 and ADON #141 confirmed storage area in the TV lounge is not a resident area and residents should not have access to the storage area as it poses a hazard.

ESM #142 placed a sheet of dry wall immediately to block access to the storage area and indicated a door with a lock would be installed within 2 weeks to prevent access to the storage area by residents as a permanent basis. [s. 9. (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 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, 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 equipment is maintained in a safe condition and in a good state of repair.

On an identified date and time resident #017 was observed sitting in a wheelchair in disrepair.

Record review of the home's "Mobility Equipment Maintenance Log" revealed resident #017's mobility device was recorded as broken and the written plan of care on a specified dated indicated the same.

Interview with RPN #700 confirmed that resident #017's mobility device was broken and needed repairs. [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 equipment is maintained in a safe condition and in a good state of repair., to be implemented voluntarily.

WN #6: 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 all areas where drugs are stored shall be kept locked at all times when not in use.

On July 10, 2015, at 11:02 a.m. the inspector observed a medication cart on an identified floor at the nurse's station unlocked and unattended.

Interview with RPN #700 revealed that he/she had left the medication cart unlocked to attend to a resident in the hallway and confirmed that the medication cart should be locked when unattended.

Interview with the Interim DOC confirmed that medication carts should never be left unlocked when unattended. [s. 130. 1.]

2. Record review of the home's Medication Reorder sheet on a specified day revealed a medication order made for resident #019.

According to the pharmacy packing slip, on a specified date an identified nursing staff received the medication as per order. The identified nursing staff reported later on that evening that the medication was missing. Home submitted a Critical Incident System (CIS) one day after, to the director related to the missing medication. Home identified the medication was found in a resident's room with no negative outcomes.

Interview with the interim DOC and Interim Administrator revealed that the home's expectation is that all medications must be locked at all times when not in use and concluded that a specified nursing staff failed to secure and lock the above mentioned medication. [s. 130. 1.]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Record review of a home's drug record books on two identified floors revealed 103 missing and/or incomplete entries between the months of January to July 2015, such as the date and signature of when the drug was ordered and/or received.

Interview with an identified staff revealed that the nurse ordering and receiving the medications should date and sign the drug record book and confirmed it was not completed.

Interview with the interim DOC confirmed that the above mentioned drug record books were not completed. [s. 133.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where a controlled substance is destroyed, including documentation as per section 136(4), to be implemented voluntarily.

WN #8: 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).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

Observation carried out on an identified date, revealed resident #043 had contact precaution sign on the door with Personal Protective Equipment (PPE) door caddie. An identified staff member was observed in the resident's room with only gloves and no gown.

A review of the resident #043's plan of care revealed the resident had a specified medical condition and staff were directed to follow the specified contact precautions.

A review of the home's policy related to the above mentioned resident medical condition directs staff to wear personal protective equipment (PPE) i.e. gloves and a gown must be donned by all staff when providing direct care to the resident."

Interview with an identified registered staff confirmed staff should have worn a gown before entering into the resident's room as the resident was on contact precautions.

Interview with IPAC lead #116 confirmed the identified staff member should have worn a gown before entering the resident's room. [s. 229. (4)] (500) [s. 229. (4)]

2. The licensee has failed to ensure that there is in place a hand hygiene program with access to point-of-care hand hygiene agents.

Observation on July 2, 2015, at 10:10 a.m., on an identified floor revealed there was no hand hygiene agents accessible to staff in residents' rooms at point of care.

Interview with an identified staff member confirmed that the identified floor did not have hand hygiene agents in the residents rooms, for residents' safety however; they keep hand hygiene agents on the care cart to access at point of care.

Observation on July 9, 2015, at 1:30 p.m., on an identified floor revealed there was no hand hygiene agents on two identified care carts.

Interview with IPAC Lead #116 confirmed that the identified floor does not have hand hygiene agents in residents rooms but staff should keep hand hygiene agents on care

carts to access it at point of care. [s. 229. (9)]

3. The licensee has failed to ensure that residents must be offered immunization against influenza at the appropriate time each year.

A review of resident #002's plan of care revealed that there was no documentation available to confirm the resident was offered immunization against influenza in an identified year.

Interview with IPAC Lead #116 and ADON #141 confirmed that the resident was not offered the above identified immunization. [s. 229. (10) 2.] (500) [s. 229. (10) 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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #9: 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 :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Observation conducted on a specified date and time, revealed resident #016's mattress was up on the head board and did not fit into the mattress stoppers. The mattress was sliding off the head board.

Observation conducted on a specified date and time, revealed resident #035's mattress was shorter than the bed and there was a visible gap between the mattress and the bed. Mattress was small to fit into the mattress stoppers.

A review of the bed entrapment audit form completed on January 22, 2015, revealed resident #035's bed failed zone 7 on the both left and right side due to a big gap between the mattress and the bed. Bed entrapment audit form was not available for resident #016's bed.

Interview with an identified maintenance staff confirmed the above mentioned resident's beds were not safe and replaced them on a same day.

Interview with Environmental Service Manager #142 confirmed that mattress should properly fit into the mattress stoppers to maintain safety. He confirmed that steps were not taken to correct the above mentioned failed zones for resident #016's bed. [s. 15. (1) (b)]

WN #10: 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 has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident has occurred or may occur shall immediately report the suspicion to the Director.

Record review of resident #017's clinical record revealed on a specified date, resident was assessed with altered skin integrity and identified skin condition of unknown cause.

Interview with interim DOC confirmed that the home suspected an alleged abuse and did not report to the Director immediately. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

An identified resident was interviewed with an identified specialist. Record review for resident #001's plan of care indicated under communication, resident required the above-mentioned specialist for communication.

Interview with identified staff confirmed it was difficult to provide care and understand the resident's needs due to a communication barrier. Identified staff confirmed that the resident did not communicate with the home language. An identified staff stated staff use nonverbal communication with resident but it does not work all the time, frustrating the resident.

Interview held with the DOC and ADON #141confirmed home does not have communication methods created to communicate with resident #001. The DOC and ADON #141 informed inspector they would speak with home staff to create visual communication aid. [s. 43.]

WN #12: 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. (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 has 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.

Observation on July 2, 2015, at 12:15 p.m., in a specified dining room revealed resident #041 was served his/her main course without feeding assistance available.

A review of the resident's plan of care revealed that the resident required total assistance for feeding by one person.

Interview with an identified registered staff confirmed that the resident required feeding assistance and the main course should not have been served to the resident until feeding assistance was available.

Interview with the Dietary Manager confirmed that food should not have been serve to the resident unless feeding assistance is available. [s. 73. (2) (b)]

WN #13: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee has failed to ensure that procedures are implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

Observation on July 10, 2015, at 1:09 p.m., and on July 13, 2015 at 1:09 p.m., revealed resident #011's personal equipment was found in an unclean manner.

Interview with the resident confirmed that he/she never refused staff to clean the personal equipment.

A review of the cleaning assignment list revealed the resident's personal equipment was last cleaned one month prior to inspection, by night PSW.

A review of the home's policy entitled Equipment Cleaning /Repairs, Index ID: RCS M-30, revised September 20, 2013, indicated the responsibility of PSW on the night shift to clean all wheelchairs weekly as per the cleaning schedule using the approved cleaning and disinfection products.

Interview with an identified registered staff confirmed that the residents personal equipment looks dirty and required cleaning.

Interview with ADON #141 (ADON) confirmed that the personal equipment should be cleaned by night PSW. [s. 87. (2) (b)]

WN #14: 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 are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies.

On July 9, 2015, on an identified floor the inspector observed the following items in the narcotic bin of the medication cart: money in clear plastic bags, a gold pocket watch, a black wallet, a pulse oximetry, duct tape, and several roles of pharmacy change of direction labels.

An identified registered staff member stated the home stores residents' money and belongings in the narcotic bin or medication cart for security purposes.

Interview with the (A)DOC revealed that the above mentioned items should not be stored in the medication cart. [s. 129. (1)]

Issued on this 30th day of November, 2015

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

Original report signed by the inspector.