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
Jul 16, 2015	2015_382596_0006	T-1766-15	Resident Quality Inspection

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue Woodbridge ON L4L 1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court Woodbridge ON L4L 9T3

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

THERESA BERDOE-YOUNG (596), JANET GROUX (606), JOELLE TAILLEFER (211)

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): May 20, 21, 22, 25, 26, 28, 29, 2015 and June 1, 2, 2015.

The following complaint inspection intake was inspected concurrently during this RQI: T-1337-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), associate director of care (ADOC), office manager (OM), director of environmental services (DES), director of support services (DSS), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), housekeeping aide, dietary aide, resident council chair, family council chair, family members, private caregiver, student registered practical nurse and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 every residents 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 is promoted.

Record review of on identified resident's progress notes indicated that the resident was repositioned every two hours, using the call bell repetitively, and requesting assistance to be repositioned. The resident was restless, diaphoretic, irritated, possibly disoriented and was in pain. An identified Registered nurse (RN) opened the window curtains, turned on the resident's fan, and stayed with the resident for twenty minutes keeping the resident company.

Record review of the identified resident's written plan of care indicated to reposition the resident every two hours and as requested, with the assistance of two staff.

Interview with an identified RN revealed that he/she refused to reposition the resident alone, until the other staff member was available. The call bell and the telephone were not removed, and the staff member asked the resident's permission to open the window curtains, turn on the fan and stayed in the room. The resident did not communicate his/her wishes. The curtains were closed and fan turned off immediately when requested by the resident.
Record review of progress notes and interview with the above mentioned RN confirmed that the resident was offered an analgesic and refused.

Record review and interview with the director of care (DOC) revealed that the home's investigation confirmed the above actions taken by the RN and that the staff member did not explain the intent of his/her actions to the resident.

Interview with the DOC confirmed that the identified staff did not treat the resident with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [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, 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.

On May 25, 2015 at 1:30 pm on an identified floor the inspector observed a Point of Care (POC) monitor in the corridor with the screen displaying a resident's personal health information.
It was visible to anyone walking by.

Interview with an identified personal support worker (PSW) revealed that he/she was using the point of care (POC) to document then went away to provide care to a resident, and forgot to close the screen. Another identified PSW proceeded to close the screen of the POC. Both of the above mentioned PSWs confirmed that the screen should not have been left open displaying a resident's personal health information. [s. 3. (1) 11. iv.]

3. On May 20, 2015, on an identified floor the inspector observed a POC monitor beside

the spa room, with the screen displaying an identified resident's personal health information. It was visible to anyone walking by.

Interview with an identified PSW revealed that staff are expected to close the POC screen when unattended. Interview with an identified RN confirmed that the POC screen should not be left open if unattended by staff, in order to keep residents personal health information confidential. [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 every residents 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 is promoted, and 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, 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, 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.

Record review of an identified resident's plan of care directs staff to provide extensive to total assistance with mouth care twice daily.

Interview with an identified PSW revealed that assistance with mouth care was not provided to the resident on an identified morning in May 2015, because the resident did not ask for assistance, and he/she had not checked the resident's care plan in over one year.

Interview with the above mentioned resident confirmed that he/she required assistance with mouth care on the identified morning in May 2015, and did not receive it. [s. 6. (7)]

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. 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 kept closed and locked when they are not being supervised by staff.

On May 20, 2015, the inspector observed a spa room, servery and clean utility room were unlocked and unattended. The following was noted by the inspector:
-the spa room across from an identified resident's room was unlocked and unattended by staff. A spray bottle of tub cleaner was left on the counter across from the tub,
-the servery door on the fourth floor was unlocked and left unattended by staff, with knives and a pair of scissors on the counter, as well as a steam table,
-the hair salon's door was open with two blue tubes of conditioner on the counter beside the sink. There were also two drawers left unlocked with hair cutting items such as a hair dryer, hair cutting attachments, and numerous plastic bags.

Interviews with identified staff revealed that the home's practice is that the spa rooms, serveries, and clean utility rooms are to be locked at all times when unattended by staff. Interview with the director of environmental services (DES) and the administrator confirmed that although the home's practice is to keep the hair salon's door open for residents' accessibility, the drawers containing the above mentioned items should have been locked. [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 that all doors leading to non-residential areas must be kept closed 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. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review of an identified resident's progress notes revealed that on an identified date in May 2015, the resident sustained a new skin tear. On a later identified date in May 2015, the skin tear healed. Record review for a period of ten days in May 2015, revealed that there was no assessment completed related to the identified resident's skin tear.

Interview with an identified RPN revealed that the home's practice is for registered staff to initiate a skin and wound assessment in the progress notes under "Observation Note", and confirmed that the home does not use an assessment tool for skin tears. Interview with the assistant director of care (ADOC) confirmed that the expectation is for registered staff to initiate a skin and wound assessment for residents' skin tears in the progress notes under "Observation Note", and not on any other assessment tool. [s. 50. (2) (b) (i)]

2. Record review of an identified resident's progress notes revealed that on an identified date in May 2015, a small skin tear was noted related to a fall. On another identified date

in May 2015, the resident sustained a small skin tear. The resident was also noted to have redness on a specified area. Further record review revealed that there was no skin assessment completed for the above mentioned skin tears.

Interview with an identified RPN revealed that a skin assessment was not completed for the identified resident's skin tears and it should have been. Interview with the ADOC confirmed that the expectation is for registered staff to initiate a skin and wound assessment for resident #12's skin tears in the progress notes under "Observation Note", and not on any other assessment tool. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that residents' exhibiting altered skin integrity, including skin tears has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review of an identified resident's progress notes revealed that on an identified date in May 2015, the resident sustained a skin tear and it healed in the month of May 2015. There was no assessment for a period of ten days in May 2015.

Interview with an identified RPN revealed that the home's practice is to assess and document skin tears weekly, and it was not completed. Interview with the ADOC confirmed that registered staff are expected to assess residents' skin tears weekly. [s. 50. (2) (b) (iv)]

4. Record review of an identified resident's progress notes revealed that the resident had altered skin integrity between July 2014 to May 21, 2015 and indicated the following:
-Two identified dates in August 2014 and one in January 2015, redness was noted,
-One identified date in May 2015, a small skin tear noted related to a fall, and
-another identified date in May 2015, a small skin tear related to the side rail and from sitting on the walker.

Interview with an identified RPN revealed that the home's practice is to complete a weekly assessment in the progress notes under "Observation Note" and confirmed that this was not being consistently done for the identified resident's impaired skin integrity issues as mentioned above. Interview with the ADOC revealed that the expectation is for weekly assessments to be completed for all skin issues. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin tears receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, and that residents' exhibiting altered skin integrity, including skin tears has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: 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 has failed to ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.

On May 21, 2015, on an identified floor in the hallway beside the dining room, the inspector observed a large bottle of Lactulose left unattended on top of the medication cart.

Interview with an identified RPN revealed that he/she had left the medication cart to administer a medication to a resident and confirmed that the Lactulose should have been put away in the medication cart. [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 #6: 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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

Record review of the home's policy entitled Skin and Wound Care Management Protocol #VII-G-20.10 current revision September 2013, directs registered staff to refer any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to the registered dietitian for assessment.

Interview with an identified RN revealed that the home does not refer all residents' with skin tears to the registered dietitian for assessment, and confirmed that an identified resident's skin tear was not referred to the registered dietitian.

Interview with the ADOC revealed that the home's policy indicated that skin tears are to be referred to the registered dietitian and confirmed the policy was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

2. Record review of an identified resident's clinical records from July 2014 to May 2015, revealed that the resident exhibited altered skin integrity including skin breakdown, and skin tears.
Record review of the home's policy entitled Skin and Wound Care Management Protocol #VII-G-20.10 current revision September 2013 directs registered staff to refer any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to the registered dietitian for assessment.

Interview with an identified RN revealed that the home does not always refer all residents' with skin tears to the registered dietitian for assessment, and confirmed that an identified resident's altered skin integrity was not referred to the registered dietitian.

Interview with the ADOC revealed that the home's policy indicated that all residents exhibiting altered skin integrity are to be referred to the registered dietitian and confirmed the policy was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

Record review of an identified resident's care plan dated March 28, 2015, directs staff to provide the resident assistance with mouth care twice daily during a.m. and p.m. care. Resident will swish and gargle mouthwash but has difficulty gripping/holding toothbrush.

Interview with the identified resident and resident's friend revealed that the resident regularly does not receive assistance with oral care in the mornings, and did not receive oral care on an identified morning in May 2015. Resident's friend assists resident with oral care in the evenings.

Interview with an identified PSW revealed that he/she was trained by another PSW not to brush resident's teeth in the morning, but rinse mouth with water. The identified PSW reported that she rinsed the resident's mouth with water on the above mentioned morning in May 2015, and did not assist the resident to swish and gargle with mouthwash and brush his/her teeth, since the resident did not ask for assistance. [s. 34. (1) (a)]

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

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information for the purposes of subsections (1) and (2) that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents is posted.

On May 20, 2015, the inspector observed the home's policy to promote zero tolerance of abuse and neglect of residents was not posted.

Interview with the home's administrator confirmed that the home did not have the policy posted. The administrator posted the home's policy entitled Abuse and Neglect of a Resident-Actual or Suspected, # VII-G-10.00 after the interview. [s. 79. (3)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents' and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the home's 2014 residents' and family satisfaction surveys revealed that there were no questions to measure the satisfaction of programs provided in the home such as: skin and wound care, falls, Occupational Therapy (OT), and restraints.

Interview with the administrator confirmed that questions to measure the satisfaction with the above mentioned services and programs provided in the home were not included in the 2014 residents' and family satisfaction surveys. [s. 85. (1)]

WN #10: 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 May 28, 2015, on the second floor the inspector observed a pair of eye glasses in a case stored in the third drawer of a medication cart.

Interview with an identified RN revealed that the eye glasses belonged to one of the residents and confirmed that the eye glasses should not be stored in the medication cart and removed it. [s. 129. (1) (a)]

WN #11: 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 the following information is recorded in respect of every drug that is ordered and received in the home: the date the drug is ordered, the signature of the person placing the order, the date the drug is received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home.

Record review of the drug record book on the second floor revealed that on pages #08301 to #08310, a total of 141 entries were missing, with either the dates and/or signature of when the medication was ordered and/or received.

Interview with two identified registered staff confirmed that the practice in the home is that registered staff ordering and receiving medications should indicate the date of when the medications are ordered and received, and sign off in the drug record book. [s. 133.]

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

On May 21, 2015, the inspector observed in a shared bathroom, an unlabelled, old, discolored toothbrush with worn bristles.

Interview with an identified RPN revealed that the toothbrush belonged to one of the residents residing in that room and that the discolored toothbrush should have been labelled. Interview with an identified registered staff revealed that the home's practice is to label residents' toothbrushes and confirmed that the discolored toothbrush was not labelled. The toothbrush was replaced.

On May 21, 2015, on an identified floor the inspector observed a used unlabelled bar of white soap on the counter by the sink, in a shared resident bathroom.

Interview with two identified staff confirmed that they did not know who the soap belonged to and that the soap should have been in a container and labelled. An identified PSW then discarded the soap. [s. 229. (4)]

Issued on this 13th day of August, 2015

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

Original report signed by the inspector.