Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 5, 2015	2014_299559_0027	T-063-14	Resident Quality Inspection

Licensee/Titulaire de permis

SPENCER HOUSE INC.
835 West Ridge Blvd ORILLIA ON L3V 8B3

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

SPENCER HOUSE INC.
835 West Ridge Blvd. ORILLIA ON L3V 8B3

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

ANN HENDERSON (559), LYNN PARSONS (153), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 12, 13, 14, 17, 18, 19, 20, 21, 24, 25 and 26, 2014.

The following complaint logs were inspected: T-748-14, T-1200-14, T-1274-14 and the following critical incidents logs: T-332-14, T-748-14, T-1171-14, T-1176-14, T-1178-14, T-1274-14.

During the course of the inspection, the inspector(s) spoke with executive director (ED), director of care (DOC), associate director of care (ADOC), director of programs and admissions (DPA), environmental service manager (ESM), maintenance, director of dietary services (DDS), registered dietitian (RD), infection control practitioner (ICP), public health nurse (PHN), registered nurse (RN), registered practical nurse (RPN), clinical pharmacist (CP), personal support worker (PSW), laundry aide, lead laundry hand, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

15 WN(s)
11 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs.

An identified resident revealed staff do not always close the privacy curtain or room door when the resident is using the bedpan and the roommate's spouse has walked into the room and passed the resident when he/she was using the bedpan. On an identified date and time, the inspector saw the open door, knocked on the door, entered the room and started a conversation with the resident, who then informed the inspector that he/she was on the bedpan and neither the privacy curtain or door were closed. Staff interviews confirmed the expectation is for the privacy curtain to be closed to ensure the resident is afforded privacy in treatment and in caring for the resident's personal needs. [s. 3. (1) 8.]

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 fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs, 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. (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 :

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

On an identified date, the inspector observed while checking the prescription creams on an identified floor, the following:
two identified residents' prescription creams did not give clear directions as to where to apply the prescription creams.

Interviews with the registered nursing staff, ADOC and DOC confirmed that all drugs are administered to residents in accordance with the directions for use specified by the prescriber, however, the prescription labels did not identify where to apply the creams. The directions were not clear. [s. 6. (1) (c)]

2. 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 revealed an identified resident's kardex and care plan stated to monitor and record the resident's wandering every hour and for safety every 30 minutes. The dementia observation system (DOS) tool was used for this purpose.
The inspector observed the DOS tool was incomplete over a period of time between two identified dates. During this time period there were 20 weeks of DOS documentation. During the 20 weeks when DOS was documented there were 35 days out of 140 days that the staff completed the documentation for a 24 hour period.
Interviews with the responsive behavior team lead and DOC confirmed the staff did not ensure the DOS tool was completed and care was not provided as specified. [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 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 failed to ensure that any policy, protocol or procedure instituted or otherwise put in place is complied with.

A review of the home's policy and procedure, titled Extended Spectrum Beta Lactamase (ESBL) #V6-060 revised August 2013, directed staff to update the resident's care plan as an additional precaution for ESBL.
A review of resident health records revealed 15 resident care plans were not updated when lab tests confirmed the presence of ESBL.
Interviews with the ICP and the ED confirmed the identified residents' care plans were not updated when the identified residents were diagnosed with ESBL. [s. 8. (1)]

2. Record review revealed an identified resident fell on two different dates. The home's policy Falls Prevention Program #V3-630 identifies after a fall the registered staff will notify the power of attorney/substitute decision maker (POA/SDM) promptly.
Documentation for the fall that occurred on an identified date and time,revealed the POA was not contacted promptly and for the fall on the second date,the POA was not called.
An identified registered nurse revealed it is the expectation the POA/SDM would be called for these falls on the day shift. The DOC confirmed this is the expectation and the POA/SDM were not contacted promptly and the home's policy was not complied with. [s. 8. (1) (b)]

3. Review of the homes’ policy titled Medications – Emergency Drug Box, #V3-940, revised April 13, 2014, states in the policy “each Leisureworld Home will maintain an approved supply of emergency medication in a locked emergency medications box in a locked medication room or cupboard in a designated area”. This policy identified “Medications not approved by the Medical Director cannot be supplied by the pharmacy

for the emergency drug box". The policy further indicates under the procedure section the following "For narcotics used from the Emergency Drug supply, ensure the appropriate narcotic count sheet is prepared and/or completed".

The inspector observed on an identified date, the emergency medications box. This box did not contain the approved supply of medication. The following medications were either over supplied or under supplied.
Amoxicillin 250mg under by 13
Amoxi-Clav 250mg under by 3
Amoxi-Clav 500mg under by 11
Azithromycin 250mg under by 1
Cefuroxime 250mg (Ceftin) under by 4
Keflex 250mg under by 7
Cipro 500mg under by 12
Biaxin 250mg under by 4
Cloxacillin 250mg under by 6
Levaquin 500mg over by 4
Flagyl 500mg under by 7
Avelox 400mg under by 2
Macrobid 100mg under by 12
Macrobid 50mg under by 10
Noroxin 400mg under by 8
Bactrim 400/80 under by 12
Imodium 2mg over by 2
Tetracyline 250mg under by 6
Coumadin 1mg under by 1
Coumadin 2.5 mg under by 1
Coumading 2mg under by 11
Lasix 20mg over by 2
Immodium 2mg under by 3
Lorazepan 1mg under by 11
Prednisone 5mg under by 9
Adrenalin 1:1000x1ml injectable under by 1
Diazepam 10 mg/2ml injectable under by 1
Lasix 20mg/2ml injectable over by 6
Haldol 5mg/ml injectable under by 1
Benadryl 50mg/ml x 1 ml injectable over by 4
Lorazepam 4 m/ml inj should be 4 under by 4

Statex over by 4
Scopolalmine 0.4mg/ml injectable under by 1.

Also contained in the emergency drug box was 3 vials of Naloxone 0.4mg/ml, this drug was not identified on the emergency drug list.

The inspector observed one of the two Statex 5mg count sheets had the wrong prescription number identified on it. This sheet was audited on an identified date and was identified as being the correct count for the prescription.

The ADOC confirmed the above counts were accurate and the home did not comply with the policy and an approved supply of emergency medication is maintained in the emergency drug box. They also confirmed the Statex narcotic count sheet had the wrong prescription number on it.

The home's policy titled Medication Management – Drug Destruction,#V3-930, revised April 2013, indicates the following “Medications that are to be destroyed and disposed of are to be stored safely and securely. Leisureworld suggest that each nursing station will have a known storage area for discontinued or outdated medications that is separate from drugs that are currently available for administration”.

The inspector observed on an identified date, in an identified medication room in the upper cupboards with routine stock medication the following:
25 ampoules of Sodium Chloride 0.9 percent with expiry date of December 2013, and 1 bottle of Isopto Tears 0.5 percent in stock cupboard with expiry date of August 2014.
The medication room has a specific container to dispose of discontinued medications.

The ADOC and DOC confirmed these medications should have been destroyed and should not have remained in the stock medication cupboard. The home did not follow the above mentioned policy [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any policy, protocol or procedure instituted or otherwise put in place is complied with and is, 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 failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

On an identified date, the following areas were observed to be unlocked :
an identified home area
- servery door with access to sharp knives and a push button coffee machine
an identified home area
- tub room door
an identified home area
- tub room with access to personal care products and razors
- servery door with access to sharp knives and a push button coffee machine.

On an identified date, the following area was observed to be unlocked:
an identified home area
- servery door with access to sharp knives and a push button coffee machine.
An interview with the ESM confirmed the identified doors should be locked when not being supervised by staff. The ESM indicated new door entry systems will be purchased and replaced. [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 are locked when they are not being supervised by staff is, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee shall protect residents from abuse by anyone.

At an approximate date and time, an identified resident entered another identified resident's room. Record review revealed an identified resident was at second identified resident's bedside, struck the resident across the face multiple times as well as hit the resident's arm. An identified resident's face was red when staff assessed the resident after the altercation. Interventions in the plan of care instructed staff to redirect and intervene when the identified resident wandered into other resident rooms and becomes physically and verbally abusive. The administrator confirmed the home failed to protect an identified resident from abuse. [s. 19. (1)]

2. Record review of an identified resident, revealed on an identified date , an identified resident was observed by a registered nursing staff to have lifted an identified resident's shirt and attempted to fondle the resident's body. The registered nursing staff member intervened and removed the identified resident.
An interview with an identified staff member confirmed the occurrence of the incident. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to protect residents from abuse by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including any risks related to nutrition care.

An identified resident had a nutritional risk related to a significant unplanned weight loss two identified dates. A record review and an interview with the RD revealed the identified resident's energy needs was not a component of the nutritional assessment. An estimated nutritional requirement for the resident's energy needs was not calculated and compared with an estimated nutritional intake. As a result, it is unclear to the RD if adequate energy to compensate for unplanned weight loss and maintain goal body weight as identified in the resident's plan of care was being offered. The resident lost an additional 1.0 kilogram the following month. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the registered dietitian who is a member of the staff of the home completes a nutritional assessment for the resident when there is a significant change in the resident's health condition including any risks related to nutrition care, to be implemented voluntarily.

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 failed to ensure that the resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

An identified resident revealed he/she does not wear bottom dentures as they do not fit and in the past had an ulcer on the lower gum area. Staff interviews revealed PSWs assist the resident with denture cleaning, know the resident wears the top dentures only and thought this was the resident's personal choice as the resident was on pureed food. The resident has not been offered an annual dental assessment and this was confirmed by the DPA. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours.

Record review for an identified resident, revealed there was no care plan developed to address wandering behaviour. Staff interviews of PSWs and registered nursing staff confirmed the resident, did wander and displayed other responsive behaviours. The home did not develop or implement strategies to address the resident's wandering behaviour. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following are developed to meet the needs of residents with responsive behaviours: written approaches to care, including screening protocols and strategies, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 118. Information in every resident home area or unit
Every licensee of a long-term care home shall ensure that the following are available in every resident home area or unit in the home:
1. Recent and relevant drug reference materials.
2. The pharmacy service provider's contact information.
3. The contact information for at least one poison control centre or similar body.
O. Reg. 79/10, s. 118.

Findings/Faits saillants :

1. The licensee failed to ensure that recent and relevant drug reference materials are available.

On an identified date, the inspector observed in an identified medication room, a plasticized package of MediSystem Facts sheets supplied by MediSystem, the pharmaceutical supplier, of relevant drug reference material. In this package was a fact sheet on Eye Drop Storage Guidelines, dated March 30, 2009. The fact sheet identified Timoptic drops should be stored at room temperature for 90 days after opening.

In the MediSystem Pharmacy manual, policy #04-10-20, review date of June 23, 2014, identified Timoptic drops should be stored at room temperature for 60 days after opening.

Interviews with the ADOC and DOC confirmed that the recent and relevant drug materials were not updated. [s. 118.]

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 recent and relevant drug reference materials are available are, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a member of the registered nursing staff permits a staff member who is not otherwise permitted to administer a drug to a resident, to administer a topical, the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

Record review revealed an identified resident receives a topical cream twice daily. Interviews with a PSW confirmed he/she applies topical ointment to the resident and the identified PSW has not been trained.

Interviews with the registered nursing staff, ADOC and DOC indicated they do allow the PSWs to apply topical creams and the PSWs have been trained. However,the DOC confirmed not all of the new PSWs had received training. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure;
- a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident, to administer a topical, if the staff member that has been trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #11: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident admitted to the home has been screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening is available to the licensee.

a) A review of the tuberculosis screening for an identified resident, who was admitted on an identified date, revealed a mantoux step 1, was administered on an identified date, which was 26 days after admission and the result was negative.

b) A review of the tuberculosis screening for an identified resident, who was admitted on an identified date, revealed a chest x-ray was completed on an identified date, which was thirty-one days after admission. A further review revealed the resident is under the age of 65 years old and was provided a chest x-ray rather than a mantoux step 1 and 2 as per best practice as directed by Simcoe Muskoka Public Health Unit.

An interview with the ADOC confirmed the tuberculosis screening was not completed within 14 days of admission for the above residents. [s. 229. (10) 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 each resident admitted to the home has been screened for tuberculosis within 14 days of admission, to be implemented voluntarily.

WN #12: 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 failed to ensure that the home and furnishings are kept clean and sanitary.

a) Observed the privacy curtains in a resident's room to be soiled on the following dates: four different dates during the inspection.
During a tour with the ESM on an identified date, it was confirmed the privacy curtains needed to be removed and sent to the laundry for cleaning.

b) Observed a chair by the window in resident's room to be soiled with brown stains on the seat cushion on the following dates:
four different dates during the inspection.
During a tour with the ESM on an identified date, it was confirmed the chair needed to be removed and cleaned.
The chair was removed and another chair was put in place. [s. 15. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

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

The following air temperatures were observed in resident's room:
on an identified date, at 9:18 a.m. 20.4 degrees Celsius
on an identified date, at 11:25 a.m. 20.7 degrees Celsius
The maintenance staff addressed the issue and on an identified date, at 8:05 a.m. the temperature was observed to read 22.4 degrees Celsius. [s. 21.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical
Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Review of the home's strategic planning and annual evaluation and an interview with the ED on an identified date, confirmed that the annual evaluation of the medication management system on an identified date, was conducted by DOC, ADOC, registered staff and the pharmacist. The medical director, RD and ED did not participate in the annual evaluation of the medication management system. [s. 116. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area that is used exclusively for drugs and drug-related supplies.

On an identified date, the inspector observed in an identified medication room, a plastic food container containing someone’s food and purse.

Interviews with the registered nursing staff, ADOC and DOC confirmed that the medication room is for medications only. [s. 129. (1) (a)]

Issued on this 7th day of January, 2015

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

Original report signed by the inspector.