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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Sep 11, Oct 23, 2015	2015_290551_0021	O-002376-15	Resident Quality Inspection

Licensee/Titulaire de permis

ALMONTE GENERAL HOSPITAL
75 SPRING STREET ALMONTE ON K0A 1A0

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

FAIRVIEW MANOR
75 SPRING STREET ALMONTE ON K0A 1A0

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

MEGAN MACPHAIL (551), ANGELE ALBERT-RITCHIE (545), JOANNE HENRIE (550)

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): August 17-21, 24-27, 2015 and September 8, 2015.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, a Dietary Aide, the Registered Dietitian, the Assistant to the Residents' Council, the Ward Secretary, a Front Office Staff Member and the Director of Resident Care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
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
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **0 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. 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Resident #1 has several medical conditions.

During an interview with Resident #1 he/she indicated to Inspector #545, that he/she required assistance to clean his/her denture due to fear of dropping and breaking it. The Resident indicated that not all staff provided assistance with the brushing of the upper denture twice daily.

According to the most recent assessment, Resident #1 required the extensive assistance of one person for personal hygiene which includes brushing of teeth/dentures.

According to Resident #1's most recent Plan of Care, he/she has an upper denture and some bottom teeth, and the Resident cleans his/her own teeth and denture in the morning and evening.

The KARDEX indicated that the Resident required extensive assistance with mouth care.

During interviews with PSWs, S #101 and S #104 on August 24, 2015, they indicated that the Resident is able to brush his/her own teeth and upper denture, and that the resident did it after each meal. PSW #S104 indicated that the Resident does not want to soak the denture at night and insists on keeping it in his/her mouth.

On August 24, 2015, PSW, S #111 indicated that Resident #1 required setup assistance and cueing for the brushing of his/her teeth and total assistance with the brushing of the denture, and that the Resident handed the denture to staff for cleaning every morning and every evening. PSW, S #111 stated that on occasion the Resident tried to brush the denture however he/she was unable to do it properly, and staff would have to re-brush the denture.

As such, Resident #1's Plan of Care does not set out clear directions related to Dental Care, to staff and others who provide direct care to Resident #1. [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.

Inspector #550 observed that the following residents, in the secured unit dining room, received half a serving of a sandwich on different days at lunchtime:

Residents #16, #18, #41, #42, #43, #44, #45, #46, #47, #48, #49 and #51.

Inspector #550 reviewed the diet report which indicates the residents' diets and any special considerations for the above residents. It was noted that none of these residents have special diets requiring half portions or special considerations that require being served half a sandwich at a time.

During an interview on August 17, 2015, Dietary Aide, S #105 indicated to Inspector #550 that the residents are always given half a sandwich because they do not like to have a lot of food on their plate, and that they can always request another half if they want.

Inspector #550 reviewed the serving summary, which indicates what portion sizes are to be served, for all the different diets offered (regular, modified diabetic regular, regular modified mince, regular puree, cardiac regular, renal regular, and diabetic renal regular) for Monday, August 17th, Thursday August 20th and Friday August 21st, 2015. It was

noted that the portion size for a sandwich for all of those diet is one sandwich.

Inspector #550 reviewed the written plan of care for the residents specified above, and it was noted that none of these residents have special diets or considerations requiring half portions.

During an interview on August 24, 2015, the Registered Dietitian indicated to Inspector #550 that one serving of a sandwich is a whole sandwich unless it is specified otherwise for a specific resident on the diet report and in the resident's care plan. She indicated that all of the above residents should have received a whole sandwich. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in Resident #11's plan of care with regards to bathing is documented.

Resident #11 is diagnosed with multiple medical conditions.

The most recent assessment indicated that Resident #11 required the physical assistance of two persons for personal hygiene and bathing. It indicated that the Resident resists care on a daily basis, and that the behaviour is not easily altered.

The Master Bathing Schedule indicated that Resident #11 was to receive a shower twice weekly.

In a review of the Daily Flow Sheets for the months of June, July and August 2015, out of 13 weeks (or 26 bath days), it was documented that the Resident had received:
- 1 bath
- 8 showers
- 3 bed baths
- 1 refusal

On August 27, 2015, during an interview with PSWs, S #104 and S #123, they indicated that the Resident's preferred method of bathing was a shower. Both PSWs indicated that they were expected to indicate "R" for refusal if the Resident refused to be bathed and to notify the registered staff. In reviewing the daily flow sheet, they indicated that refusal should have been indicated, but was not, and that the Resident had probably received a bed bath.

On August 27, 2015 during an interview with PSW, S #113 she indicated that Resident

#11 had refused a shower on a specified day on August 2015 and that a bed bath had been provided. PSW, S #113 indicated that she had not documented that Resident #11 had refused a shower or that he/she had been given a bed bath on the Daily Flow Sheet as was the documentation expectation.

During an interview with RN, S #109 on August 27, 2015 she indicated that Resident #11 was known to refuse care, and that according to the Master Bath Schedule he/she should be offered a shower twice weekly. On the same day, RPN, S #117 indicated that the Resident was known to refuse care. The staff member reviewed the progress notes and indicated that there was no documentation to support that the resident was refusing to be bathed, and that the expectation was there would be a progress note entry if it was reported to a registered staff member by a PSW that care had been refused. [s. 6. (9) 1.]

WN #2: 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 that the home's front door key pad was in a good state of repair.

To enter and exit the building residents, visitors and staff members must use an electronic key card or enter a code into a panel box to unlock the door.

On August 27, 2015, upon exiting the home through the front door, Inspector #545 entered the wrong code and the door unlocked providing unrestricted access to outside of the building. Several random numbers were tried and the door continued to unlock. This was brought to the attention of S #114 who works in the business office, which is located next to the front entry way, who indicated that she would bring this to the attention of the Director of Resident Care.

On September 8, 2015, the Director of Resident Care indicated to Inspector #551 that a lock smith had been in on August 28, 2015 and had repaired the front door key pad. She stated that residents who exit the building use electronic key cards and that there were no negative outcomes to the residents as a result of the malfunction. [s. 15. (2) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that alternatives to the use of a Personal Assistance Services Device (PASD) have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with an activity of daily living.

As per LTCHA 2007, c. 8, s. 33 (1), the above requirement applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD.

On August 18 and 24 and 25, 2015, Resident #2 was observed to be using a front closing seat belt while seated in his/her wheelchair.

On August 24, 2015, in the presence of Inspector #551, Resident #2 was not able to cognitively or physically release the seat belt when asked to and cued by PSW, S #104.

On August 25, 2015, in the presence of Inspector #551, Resident #2 was not able to cognitively or physically release the seat belt when asked to and cued by PSW, S #113.

According to PSW, S #104 Resident #2 wears a front closing seat belt for positioning and stated that due to impaired skin, Resident #2 cannot use the foot rests to support his/her position. According to the Director of Resident Care, Resident #2 wears a front closing seat belt for safety and positioning but does not consider it as a restraint as the resident can at times undo the belt. She stated that the seat belt was used to prevent the resident from leaning too far forward.

Resident #2's health care record was reviewed. Resident #2 has resided at the home since 2012 and requires full assistance for most of his/her activities of daily living. Several staff members were interviewed and could not recall when the seat belt was implemented. A progress note entry three months following admission to the home indicates that Resident #2 was wearing a front closing seat belt at that time.

There was no documentation to support that alternatives to the use of the seat belt as a PASD were considered or tried. This was confirmed by the Director of Resident Care. [s. 33. (4) 1.]

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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 the resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from an absence of greater than 24 hours.

On a specified day in August 2015 Inspector #550 observed that Resident #26 had many red bruises.

On a specified day in August 2015 Inspector #550 observed that Resident #26 had a Tegaderm on a specific body part.

Resident #26's health care record was reviewed, and it was noted that on a specified day in August 2015, he/she sustained a laceration to a specific body part. An entry in the progress notes indicated that the resident was out of the home on a leave of absence for a period of time that was greater than 24 hours.

During an interview RPN, S #122 indicated to Inspector #550 that the resident had constant bruising. She indicated that Resident #26 should have received a skin assessment upon return from a leave of absence greater than 24 hours, but could not find evidence to support that this was done.

During an interview RN, S #109 indicated to Inspector #550 that a skin assessment needs to be completed upon any return of a resident from an absence greater than 24 hours. She indicated that she was unable to verify that a skin assessment had been completed for Resident #26 upon return from a leave of absence greater which was greater in length than 24 hours. [s. 50. (2) (a) (iii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

On a specified day in August 2015, Inspector #550 observed that Resident #26 had many red bruises.

On a specified day in August 2015, Inspector #550 observed that Resident #26 had a Tegaderm on a specific body part.

Resident #26's health care record was reviewed, and it was noted that on a specified day in August 2015, the resident sustained a laceration to a specific body part.

During an interview RPN, S #122 indicated to Inspector #550 that Resident #26 had constant bruising. She stated that for the laceration to the specific body part, a wound management plan - appendix A should have been completed and put in the MAR (Medication Administration Record) sheets/treatment sheets to inform the nurses of the wound, of dressing changes and documentation of the wound assessment, but she was unable to locate this assessment.

During an interview RN, S #109 indicated to Inspector #550 that a skin assessment needs to be completed on a weekly basis at a minimum when a resident is exhibiting altered skin integrity. She further indicated she was unable to find that a skin assessment had been completed for Resident #26 after the resident sustained a laceration to a specific body part on a specified day in August 2015. [s. 50. (2) (b) (i)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Residents' Council meeting minutes were reviewed for 2015. Some of the concerns or recommendations made by the members were documented, for example:
- Chairs in Garden Walk and Old Mill Place still slide with some difficulty
- Noise in Garden Walk Dining Room
- Noise in Old Mill Place halls and other Residents' rooms
- Request for more help for residents who are blind
- Various dietary concerns

During an interview with the President of the Residents' Council on August 21, 2015 she indicated that meetings occur monthly except for during the summer months when there are none. She indicated that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On August 25, 2015 the Recreation Therapist, S #108 indicated to the Inspector that she was assigned as Assistant to the Residents' Council and was responsible to bring the Residents' concerns and recommendations to the Administrator, DRC, Assistant DRC and Maintenance Manager post-meetings. She indicated that the licensee did not respond to the Residents' Council in writing within 10 days of receiving the advice or recommendations, and that responses were brought forward to the Residents' Council, at the next meeting, usually the following month. [s. 57. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure assistance in the establishment of a Family Council within 30 days of receiving a request from a family member of a resident or a person of importance to a resident who requested the establishment of a Family Council for a long-term care home.

During an interview with the Director of Resident Care (DRC) on August 26, 2015 she indicated that on January 30, 2015 she had sent a letter to all family members of Residents in the home to inform them that the home wanted to re-establish the Family Council. She further indicated that she received nine letters of interest sometime in February 2015, and that she had met with one family member who provided no restrictions on his availability. The DRC stated that she did not delegate someone to provide assistance to re-establish the Family Council and that no assistance has yet been provided to re-establish a Family Council. [s. 59. (3)]

2. The licensee has failed to ensure that semi-annual meetings were convened to advise such persons of the right to establish a Family Council.

During an interview with the Director of Resident Care on August 26, 2015, she indicated that the home's Family Council has been inactive since January 2014. She indicated that the home does not convene semi-annual meetings to advise residents' families and persons of importance of their right to establish a Family Council. She stated that the Administrator mentions it at the Annual Residents' Christmas Party each year in December but not at any other time during the year. [s. 59. (7) (b)]

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

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 copies of the inspection reports were posted in an easily accessible location.

According to LTCHA 2007, c. 8, s. 79 (3) (k) it is a requirement that copies of the inspection reports from the past two years for the long-term care home be posted in the home.

During a tour of the building on August 17, 2015, it was noted that copies of inspection reports for the home were kept in a glass display case on the ground floor. The glass display case was noted to be locked.

On August 25, 2015, the glass display case containing the inspection reports was noted to be locked. Staff Member #114 who works in the business office was interviewed and stated that she had a key and assumed that the charge nurse and members of the administration did as well. She stated that if a person wanted to view the inspection reports, the person could ask her and she would unlock the case. She stated that the normal business office hours were 9am to 3pm.

The Director of Resident Care stated that she was aware of the requirement that the inspection reports be in an easily accessible location, and agreed that when the display case was locked, the inspection reports were not easily accessible. [s. 79. (1)]

2. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home.

Copies of the inspection reports are kept in a display case on the ground floor. During a tour of the building on August 17, 2015, it was noted that there were copies of four inspection reports in the display case (2015_330573_0006, 2015_346133_0002, 2014_290551_0022, 2014_287548_0017).

A review of the home's compliance history shows that between August 2015 and August 2013, there were two additional inspection reports that were not posted (2014_200148_0009, 2013_200148_0049). [s. 79. (3) (k)]

WN #8: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the President of the Residents' Council on August 21, 2015 she indicated that she did not recall the licensee seeking the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

On August 25, 2015 the Assistant to the Residents' Council indicated to the Inspector that she was not aware of the licensee having sought the advice of the Residents' Council in developing and carrying out the 2015 satisfaction survey, and in acting on its results.

During an interview with the Director of Resident Care on August 25, 2015 she indicated

that she was responsible for developing and carrying out the Annual Satisfaction Survey, and that in 2015, it had been delivered to Residents in the month of January. She indicated that she believed that she had met privately with the President of the Residents' Council in the fall of 2014 and provided her with a sample of the satisfaction survey for her review and approval. The DOC was unable to provide evidence of having sought advice from the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee has failed document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview with the President of the Residents' Council on August 21, 2015 she could not recall the licensee having made available the results of the 2015 satisfaction survey in order to seek the advice of the Residents' Council about the survey.

On August 25, 2015 the Assistant to the Residents' Council indicated to the Inspector that she was not aware of the licensee having documented and made available to the Residents' Council the results of the 2015 satisfaction survey in order to seek their advice.

During an interview with the Director of Resident Care on August 25, 2015 she indicated that she was responsible for developing and carrying out the Annual Satisfaction Survey, and that in 2015, it had been delivered to Residents in the month of January. She indicated that she generated the results from the survey in March 2015 and may have shared the results with the Residents' Council in April 2015. After reviewing the meeting minutes for 2015, the DRC indicated to the Inspector that there was no evidence of the satisfaction survey results having been documented and made available to the Council. [s. 85. (4) (a)]

WN #9: 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,
i. that is used exclusively for drugs and drug-related supplies,
ii. that is secure and locked.

During an interview, Resident #50 indicated to RPN, S #117, in the presence of Inspector #550, that he/she kept a prescribed medication in the drawer of the night table in his/her room, and that the drawer does not lock. RN, S #109 indicated to Inspector #550 that she removed a bottle of prescribed medication from Resident #50's night table drawer, and that it was not locked.

Inspectors #545 and #550 observed on August 19 and 26, 2015, on a shelf in the Spa Room (Garden Walk), two bottles (120ml) of prescribed shampoo; one belonging to Resident #11 and the other to Resident #7.

During an interview, the Director of Resident Care indicated to Inspector #550 that medicated shampoos are kept in the locked tub and shower rooms so that they are readily accessible to PSWs. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

On August 25, 2015 during an observation of the locked medication room, Inspector #550 observed, in the medication refrigerator, a box containing eight vials of Lorazepam for injection, 4mg/ml. The medication refrigerator is not double locked.

During an interview, RN, S #109 indicated to Inspector #550 that all benzodiazepines are to be kept locked, and she was not aware that there were vials of Lorazepam in the refrigerator in the medication room. She indicated she was going to destroy them immediately.

The Director of Resident Care indicated to Inspector #550 that she was aware that all the narcotics and benzodiazepines are to be kept double locked. [s. 129. (1) (b)]

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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On August 25, 2015, RPN, S #117 indicated to Inspector #550 that Resident #50 self administers a prescribed medication, and that the resident keeps this medication in his/her room. Resident #50 confirmed with RPN, S #117, in the presence of Inspector #550, that he/she self administers, and keeps the prescribed medication in his/her room. Inspector #550 reviewed Resident #50's health records and noted a hand written note on the resident's MAR sheet indicating ''self administers'' but the inspector was unable to find a physician order for the self administration of the medication.

During an interview, RPN, S #117 indicated to the inspector that the resident should have a physician's order to be able to self administer his/her medication.

During an interview, RN, S #109 indicated to the inspector that Resident #50 is not permitted to self administer any medication, and that all of the resident's medication should be administered by registered staff. On the following day, she indicated to the inspector that she had removed the medication from Resident #50's room and explained to the resident that all of his/her medication has to be administered by a member of the registered staff. [s. 131. (5)]

Issued on this 11th day of September, 2015

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

Original report signed by the inspector.