Findings/Faits saillants :

1. Not all drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) Progress note dated April 27, 2013, at 0551 hours, identified that resident #4004, who resided in a shared room, had medications sitting on the bedside table. The medications were believed to be from the evening shift. The resident did not have an order to self administer medications or to keep medications at the bedside. Interview with the RPN confirmed that the resident was to be monitored when taking medications.
B) Progress note dated March 2, 2013, at 1038 hours, identified that resident #4005, who resided in a shared room, had medication at the bedside. The note indicated that the medication was from the 2200 hour medication pass on March 1, 2013. The resident did not have an order to self administer medications or to keep medications at the bedside. Interview with the RPN confirmed that the resident was to be monitored when taking medications.
C) Resident #6001 did not receive a medication as ordered on March 2, 2013, at 0800 hours. The progress notes indicated the resident did not receive the medication and staff confirmed the missed dosage.
D) Resident #6011 had a physician order dated February 27, 2013, that staff may leave medications at the bedside. The progress notes of April 18, 2013, at 1047 hours indicated a PSW found some of the resident's pills from the last evening untouched. The resident stated they had fallen asleep after an analgesic was given during the evening, had awaken at 0300 hours and realized they had forgotten to take the pills. The medications were discarded. The MAR included a staff initial for the 2000 hours medication to indicate the medication had been administered. The individual monitored medication record and the as needed medication sheet were signed to indicate the resident received the second medication, as required, at 2000 hours. Discussion with nursing management confirmed that when a resident had an order to leave medications at the bedside, the staff dispense the medication at the times indicated on the MAR, initial that the medication has been administered, then leave the medication with the resident. It is the expectation that staff who dispense the medication follow up to ensure it has been taken by the resident.
E) Resident #6004 did not have any of their 0800 and 1200 hour medication signed as being administered on April 28, 2013. A package containing a medication labeled for April 28, 2013, at 1200 hours, was located in the destruct box on April 29, 2013. [s. 131. (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 drugs are administered according to the direction for use by the prescriber, to be implemented voluntarily.

WN #26: 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 drug record book was not completed to ensure the book included the date the drug was ordered, the signature of the person who placed the order or the signature of the person to acknowledge receipt of the drug.

A) Resident #2010 had tylenol with codeine documented and ordered on April 28, 2013, however it was not signed as being received in the home.
B) Resident #2011 had hydromorphone documented and ordered on April 28, 2013, however it was not signed as being received in the home.
C) Resident #2012 had spiriva documented and ordered on March 19, 2013, however it was not signed as being received in the home.
D) Resident #2013 had zoladex injection documented and ordered on March 20, 2013, however it was not signed as being received in the home.
E) Resident #2014 had fucindin ointment received at the home on March 9, 2013, however the date the drug was ordered and the signature of the person who placed the order were not recorded in the drug record book.
F) Resident #2015 had synthroid received at the home on March 6, 2013, however the date the drug was ordered and the signature of the person who placed the order were not recorded in the drug record book.
G) Resident #2016 had coumadin received at the home on March 15, 2013, however the date the drug was ordered and the signature of the person who placed the order were not recorded in the drug record book.
H) Resident #6006 had fluticasone ordered on April 1, 2013. The drug record book did not include documentation of date received, who it was received by, prescription number, and quantity.
I) Resident #6005 had warfarin ordered April 16, 2013. The drug record book did not include documentation of date received, who it was received by, prescription number, and quantity.
J) Resident #6010 was ordered clonazepam on April 1, 2013. The drug record book did not include documentation of date received, who it was received by, prescription number, and quantity.
K) Resident #6007 was ordered imodium which was received on April 2, 2013. The drug record book did not include documentation of date the drug was ordered and by whom.
L) Resident #6008 was ordered lasix which was received in the home on April 4, 2013. The drug record book did not include documentation of the date the drug was ordered, by whom nor was there a record of the quantity received.
M) Resident #6009 was ordered rampil which was received in the home on April 4,

2013. The drug record book did not include documentation of the date the drug was ordered, by whom nor was there a record of the quantity received.
N) The drug record book on fourth floor north tower had epinephrine ordered for the medication room on March 3, 2013, however it was not signed in as being received.
O) Resident #2080 had emo-cort cream re-ordered, using the sticker from the medication jar, however it was not signed in as ordered or received in the home.
P) Resident #2081 had symbiocort as ordered at the home on March 2, 2013, however it was not signed in as received in the home.
Q) Resident #2082 had premarin cream ordered in the drug record book on February 28, 2013, however the drug was not signed in as received in the home.
R) Resident #2083 had valproic acid oral liquid ordered on February 17, 2013, however it was not signed as received in the home.
S) Resident #2084 had docusate liquid ordered on February 23, 2013, however it was not signed in as received.
T) Resident #2085 had ativan ordered on March 3, 2013, however it was not signed in as received by the home. [s. 133.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the drug record book is maintained and contains the information required in the regulations, to be implemented voluntarily.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. Not every resident taking a drug had monitoring and documentation of the resident's response and the effectiveness of the drug.

Resident #9863 had a new diagnosis of fractures. The treatment for pain management included analgesic and to monitor for pain. The documentation in the MAR indicated the resident received a narcotic as required 21 times the month of the diagnosis, for complaint of pain. Review of the MAR and progress notes indicated the effectiveness of the medication was documented nine times out of the 21 times the medication was administrated. [s. 134. (a)]

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 taking a drug has monitoring and documentation of the resident's response and the effectiveness of the drug, to be implemented voluntarily.

WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The home's staff did not participate in the implementation of the infection prevention and control program.

A) The "Infection Control Routine Practices INF-POL/1, last revised May 3, 2013" identified that hand hygiene is required before and after contact with any resident, their body substances or items contaminated by them. During the noon medication pass on April 29, 2013, the RPN did not use hand sanitizer between administrating medication to residents in the dining room. [s. 229. (4)]

2. Not all residents were offered immunizations in accordance with publicly funded schedules.

Residents #7002, #7004 and #7005 were not offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. The health records identified they were not offered or immunized against pneumoccocus, tetanus and diphtheria. Interview with the Infection Control Lead confirmed that the immunizations were not offered. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the infection control program, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The home was not a safe and secure environment for its residents.

A) On April 22, 2013, at 1030 hours, a dining room was unlocked and the servery door open. A resident was sitting in the room and had unsupervised access to the servery where the steam cart was readily accessible and was hot to the touch.
B) On April 22, 2013, at 1045 hours, a second dining room was unlocked and the servery door open. No staff was present in the dining room and there was full access the servery where a knife was found in one of the unlocked drawers. [s. 5.]

WN #30: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Not all plans of care were based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

The continence quarterly assessment, for resident #0883 was completed by nursing with an assessment reference date (ARD) of April 21, 2013. The assessment indicated the resident was incontinent of bowel, had inadequate control all or almost all of the time, experienced constipation and used enemas in the last 14 days. The RD assessment completed April 30, 2013, indicated the resident was prone to constipation. Bowel and bladder flow sheets and staff confirmed that the resident was incontinent of bowel. The plan last updated May 9, 2013, indicated occasional incontinence of stool related to delirium, inability to toilet self and diarrhea. The plan did not include constipation or strategies to manage despite being identified in the assessment. [s. 26. (3) 8.]

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Bath Day Skin Assessments, which were part of the home's skin and wound program were not consistently completed for resident #4006. According to the assessments the resident did not have an assessment documented in January 2013, had three assessments documented in February 2013, two assessments in March 2013 and two assessments in April 2013. PSW staff confirmed that the resident would have been examined during the activity of bathing and this information should have been documented.
B) Resident #9925, had a known history of responsive behaviours.
i) Progress notes and flow sheet for January 2013, indicated the resident refused and was resistive to care on two dates in 2013. The records did not identify interventions or actions of staff in an attempt to provide care.
ii) Progress notes and flow sheet for a month in 2013, indicated that the resident refused and was resistive to care on two dates. The documentation did not identify interventions or actions of staff in an attempt to provide care.
iii) The resident was resistive to attempts to provide care on an evening and night shift. Staff reported that a number of attempts were made to provide care however the resident refused staff efforts of assistance with activities of daily living and continence care. The flow sheet noted a refusal of care for evenings and nights however there was no other documentation in the progress notes or other tools of interventions attempted by staff or the specific response of the resident. Nursing staff confirmed that interventions or the residents response to interventions were not documented for the time period identified.
C) Not all actions taken with resident #5000 under the nutrition program, were documented. The intake of the resident's meals and snacks were not consistently recorded. The food and fluid intake form had omissions for 11 meals and 19 snacks for the month of April 2013. [s. 30. (2)]

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Not all residents received individualized personal care, including hygiene care and grooming, on a daily basis.

A) Resident #9743 was observed on April 29, 30, May 1 and May 2, 2013, with multiple long white chin hairs, some as long as three inches. According to Registered staff and the ADON, the PSW's were to provide individualized personal care such as shaving to female residents on a daily basis or as needed. Review of the flow sheets and progress notes for April 2013, did not indicate that staff provided shaving to the resident during the observed period of time.
B) Resident #9899 was observed on April 29, May 3, 9, and May 13, 2013, with multiple long white chin hairs. The PSW indicated that the resident should have been shaved on bath day. According to the flow sheet, the resident received a bath on May 1 and 4, 2013 however, was not shaved during that time. The flow sheets and progress notes for April and May, 2013, did not indicate that the staff provided shaving for the resident during the observed period of time [s. 32.]

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Not all residents received fingernail care, including the cutting of fingernails.

Resident #9989 was observed on April 29, May 9 and 13, 2013, to have soiled fingernails. Registered staff confirmed that there were no behaviours that would contribute to the soiled nails. The plan indicated extensive assistance for the care to be completed. Documentation reviewed supported that the nails were not cut or cleaned during the identified time period. [s. 35. (2)]

WN #34: 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 advice of the Residents' Council was not sought in the development and carrying out the satisfaction survey or in acting on its results.

Interviews with the President of Residents' Council, the Council Assistant and the Director of Performance/Quality and IT Systems and a review of minutes from 2012 and 2013 confirmed that the advice of Council was not sought regarding the satisfaction survey specifically related to its development, implementation and in acting on the results. [s. 85. (3)]

2. The documented result of the satisfaction survey were not made available to the Residents' Council in order to seek their advice regarding the survey.

Interview with the President of Residents' Council, the Council Assistant and the Director of Performance/Quality/IT Solutions and a review of meeting minutes for 2012 and 2013 confirmed that the results of the satisfaction survey were not formally made available to the Council in order to seek their advice regarding the survey. [s. 85. (4) (a)]

WN #35: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. Not all schedules were in place for routine, preventive or remedial maintenance.

There were no routines or schedules for the maintenance of servery cabinets. Cabinetry surfaces in the south tower for all serveries were observed to be worn down, through the varnish and down to the raw wood. The home did not have any schedules or procedures to ensure the cabinets were maintained. [s. 90. (1) (b)]

WN #36: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The home had not shared the quality improvement and utilization review system that ensured improvements made to the quality of the accommodation, care, services, programs and goods provided to residents were communication to the Family Council and staff, on an ongoing basis.

In January 2013, the Continuous Quality Improvement Committee received Risk Management Reports/Sentinel Events and there were performance indications included in the Quality Improvement Plan. The topics included pressure ulcers and restraints and these were not communicated with the Family Council or the staff. The 2013 Improvement Targets and Initiatives identified by the Quality Improvement Committee had not been shared with the staff or the Family Council. Examples include objectives to reduce use of daily physical restraints, improve provider hand hygiene compliance, reduce incidence of worsening bladder function, avoiding emergency department transfers or improving resident, staff and family satisfaction. This was confirmed by Quality Improvement staff. [s. 228. 3.]

Issued on this 4th day of July, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
original signed by L. Vinky