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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 21, 2013	2013_202165_0001	H-001751-12	Complaint

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 9 and 10, 2013.

During the course of the inspection, the inspector(s) spoke with the Recreation Managers, the Administrator, the Director of Care, Registered Practical Nurses (RPN), Registered Nurse (RN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) reviewed clinical health records, recreation monthly calendars and recreation documentation.

The following Inspection Protocols were used during this inspection:
Recreation and Social Activities

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Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 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 licensee of the long term care home did not ensure that the home was a safe and secure environment for its residents.
The door to the third floor shower room was left propped open January 9, 2013 14:00 hours with no staff present. Disinfectants (corrosive when swallowed) was out and accessible to residents. Staff confirmed that the door was to be closed and locked when unattended.
The door to the third floor shower room was left propped open January 10, 2013 14:00 hours with no staff present. The floor was wet and their was no wet floor signs in use to identify the safety risk. Disinfectants (corrosive when swallowed) was left out and accessible to residents. Several staff entered and left the shower room for at least twelve minutes however, staff did not close and lock the door. Staff confirmed that the door was to be closed and locked when left unattended.
The door to the second floor shower room was left propped open January 10, 2013 10:25 hours and at 11:40 hours with no staff present. Disinfectants (corrosive when swallowed) was left out and accessible to residents. Staff confirmed that the door was to be closed and locked when left unattended and signage on the door directed staff to keep the door closed when not in use. [s. 5.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. The plan of care for resident #1, 2, 3, 4 indicated that the resident's would receive the one to one visiting program 2-3 times per week for increased stimulation and socialization however, documentation confirmed that resident # 2,3 and 4 only received the one to one visiting program 2 times per week for 2 weeks and only once per week for the remaining weeks of December 2012. Resident #1 only received the one to one visiting program 2 times per week once, once per week for one week and no one to one visiting program for the last week of December 2012. The recreation manager confirmed that the one to one visiting program was not completed as specified in the plan. [s. 6. (7)]

WN #3: 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 of the long term care home did not ensure that drugs were stored in an area or a medication cart that was secure and locked. January 10, 2013 10:54 hours the Registered Practical Nurse (RPN) was observed dispensing medications on the second floor. The medication cart was left in the hallway outside residents rooms unlocked and unattended when the RPN entered the resident's rooms. The inspector observed this repeated practice for ten minutes.
At 11:04 hours the RPN left the medication cart outside room 203 and went down the hall and entered room 204. The RPN left the medication cart unlocked and unattended in the hallway for five minutes. The RPN confirmed that the medication cart was left unlocked and unattended for the period of time. [s. 129. (1) (a) (ii)]

Issued on this 24th day of January, 2013

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