**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## 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 2, 2015 | 2014_236572_0031 | O-001363-14 | Resident Quality Inspection |

### Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET GANANOQUE ON  K7G 2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET GANANOQUE ON  K7G 2Z1

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

BARBARA ROBINSON (572), ANANDRAJ NATARAJAN (573), SUSAN DONNAN (531), WENDY BROWN (602)

## 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): December 15-19 and December 22-23, 2014.**

**A Critical Incident Log #008613-14 (Log O-001322-14) was completed concurrently with the Resident Quality Inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Manager of the Activity Department, the Manager of Housekeeping Services, the Environmental Services Manager, a Physiotherapist (PT), family members, and residents.**

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

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

**9 WN(s)**
**3 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 9. Doors in a home**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1)1.1, whereby the licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

On December 15, 2014, during the initial tour of the building, Inspector #531 observed that a door leading to the Veteran’s Garden, an outdoor enclosed courtyard was unlocked and the area was unsupervised. The door is located at the junction of Joyce Faye and Kingsley Earl unit halls. There was a light plastic expandable gate in front of the door that was easily removed and the door opened. Inspector #572 also observed the open door shortly afterwards. Residents and family members walk along the hall frequently during the day.
On December 15, 2014, the DOC stated that the lock on the door has been broken since Friday, December 12, 2014 and that the home is waiting for a part to arrive to fix the door. She confirmed that the door is unsupervised and provides access to the courtyard which is also unsupervised in the winter. The lock was repaired and locked on December 19, 2014; it remained locked for the remainder of the RQI.

The licensee has failed to comply with O. Reg. 79/10 s. 9(2) whereby the licensee has failed to ensure that the home has a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On December 16, 2014 the DOC confirmed that the home does not have a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The licensee has failed to comply with O. Reg. 79/10, s. 9(1) 2 whereby the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to

restrict unsupervised access to those areas by residents, and to ensure that those doors are kept closed and locked when they are not being supervised by staff.

The following observations present a pattern of potential risk to residents in the home, particularly for those residents who exhibit behaviours such as wandering and/or exit-seeking:
#1: Doors to the kitchen which are accessible from the service hall- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the kitchen doors were open, unlocked, and that the area was unsupervised. The kitchen contains a stove, dishwasher, large sinks and various utensils used for food preparation. Inspector #572 also observed the open doors and unsupervised kitchen shortly afterwards, and the DOC was informed of the risk to residents from the open and unsupervised doors along the service hall. She noted that there is a Beltrac belt with wall mount stretched across the service hallway. It did not prevent three residents from entering the service hallway; two residents were redirected as they attempted to enter rooms in the area. Inspector #572 noted that by noon, the kitchen door was closed but remained unlocked and the area was unsupervised.
#2: Doors to a servery which are accessible from the service hall, a residents' lounge and a residents' dining room- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the doors to the server were open and that the area was unsupervised. There was no lock on the doors. The server contains food storage areas such as a fridge and several hot plates which are turned off when staff are not in the area. Inspector #572 also observed the open doors and unsupervised area shortly afterwards. Dietary staff reported that the room is not kept locked as it is the location of any food preparation required for residents in the evening and night shifts. There were numerous family members and residents in the dining room and lounge throughout the day.
#3: Doors to the laundry area which is accessible from the service hall- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the laundry doors were open, unlocked, and that the area was unsupervised. The laundry area contains large industrial washers and dryers as well as soap. By noon the door was locked.
#4: East Wing servery which is accessible from a hall in the home and a residents' dining room- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the East Wing servery door was open, unlocked, and that the area was unsupervised. The servery contains food storage areas such as a fridge, an ice machine and several hot plates which are turned off when staff are not in the area. Inspector #572 also observed the open door and unsupervised area shortly afterwards. By noon the

door was locked.
#5: Storage room called "Laundry Room" which is accessible from a hall in Joyce Faye Terrace- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the Laundry Room door was open, unlocked, and that the area was unsupervised. The room contains a washer and dryer, as well as numerous large tables and other items stacked against the walls. Inspector #572 also observed the open door and unsupervised area shortly afterwards. The room remained unlocked and unsupervised.
#6: Storage Room which is accessible from a hall in the Earl Kingsley Wing- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the Storage Room door was open, unlocked, and that the area was unsupervised. The room is full of wheelchairs and mobility aids. Inspector #572 also observed the open door and unsupervised area shortly afterwards. The room remained unlocked and unsupervised.
#7: West Wing storage room which is accessible from a hall in the wing- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the Storage Room door was open, unlocked, and that the area was unsupervised. The room contains restraints, medical supplies, soaps and sprays. Inspector #572 also observed the open door and unsupervised area shortly afterwards. The room remained unlocked and unsupervised.

On December 15, 2014, the DOC was notified of the list of areas where doors to non-residential areas were open, unlocked, and unsupervised. She confirmed that these areas should be closed and locked when unsupervised.
On December 19, 2014 all doors to non-residential areas were observed to be closed and locked unless supervised. They remained closed and locked unless supervised for the remainder of the RQI. [s. 9.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10 s. 8(1)(b) whereby the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system related to the skin and wound care program was complied with.

In accordance with O. Reg. 79/10 s. 30 (1)1. and O. Reg. 79/10 s.48 (1)2., the licensee is required to have a skin and wound care program including a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

The home's policy "Wound and Skin Care Protocols" was last updated in May 2010 and describes the home's skin and wound care program.
The policy states the following:
- on admission, quarterly, on return from hospital, and/or leave of absence greater than 24 hours and with the initial sign of any skin breakdown, a skin and wound assessment will be completed which includes the "Head to Toe Assessment" and the "Waterlow Score".
- if a wound is identified, "Carveth Wound Assessment Checklist" will be initiated and the check list items are to be followed through and completed.
- "Weekly Wound Measurement Tool" forms will be completed each week.
- all residents with a Stage 2 or greater wound will have a pain assessment protocol.
- residents with a wound will be added to the "Wound/Skin Tear Tracking Form".
- a full comprehensive wound assessment is to be documented monthly in the progress notes.

A review of the health care record indicates that Resident #3 has multiple co-morbidities including several pressure ulcers that have been present for five months with

complications.

“Weekly Wound Measurement Tool” forms were completed twice during five months for Resident #3 (see WN #4). An initial admission “Head to Toe Assessment” was documented but further ongoing monitoring and evaluation assessments as required by the home's skin and wound policy were not completed.

On December 23, 2014, RPN #S125 and the DOC confirmed that wound assessments are not always completed as required. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) whereby the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system related to the medication management system was complied with.

In accordance with O. Reg. 79/10, s. 136(1), the licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides ongoing identification, destruction and disposal of,
a) expired drugs.

On December 19, 2014, observation of the Nursing 1 medication drug storage for the medication cart and emergency drug stock cupboard in the Dispensary confirmed the following medications as being expired:
- 9 vials Dimenhydrinate, 50 mg/ml, expired November 2014.
- 2 vials Furosemide, 10mg/ml, expired October 2014.

Emergency Stock:
- Contreles Allergy Formula, (Diphenhydramine HCL 25mg), expired November 2014.

Expired medications in the medication refrigerator:
- 7 suppositories, Gravol Suppository for Children, 50mg, expired November 2014.
- 10 suppositories, Gravol Suppository for Children, 50mg, expired September 2014.

Medication cart:
- Ducosate Sodium tabs, 100mg, expired April 2014.

On December 22, 2014, a review of the Record Keeping section (2.4.3) in the "Pharmacy Policy and Procedure Manual" indicated that where an emergency medication supply is provided to a long-term care facility, the pharmacist or designate periodically verifies the contents to ensure products are within their expiry date.

On December 22 , 2014, RPN #S109 was interviewed and confirmed that the night nurse

was responsible for checking the medication areas on a weekly basis for expired drugs. RPN #S109 confirmed that the night nurses' duty schedule is posted in the Nursing 1 medication room on a monthly calendar.

On December 22, 2014, the DOC was interviewed and confirmed that the night nurses have a calendar posted of scheduled duties and that the home's expectation is to have routine checks completed regularly for expired drugs. [s. 8. (1) (b)]

3. The licensee has failed to comply with O. Reg. 79/10 s. 8(1)(b) whereby the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system related to missing items is complied with.

In accordance with O. Reg. 79/10 s. 89(1)(a)(iv), the licensee is required to have procedures developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

In an interview on December 16, 2014, Resident #34 and Resident #27 stated that they had lost personal items and reported the loss to staff in the home.

Procedure #5 in the home's current policy "Residents' Loss of` Items" states the "When personal property is lost, the Registered Staff on duty at the time the loss is reported will fill out an investigation of loss form (Missing Items Report) to help identify the property and all pertinent information pertaining to the loss."
Procedure #6 states "A description of the lost article will be placed in the report book for either clothing or an article so that front line staff may also begin a search."

On December 22, 2014, RPN #S109 was interviewed about the missing remote control and confirmed that she documented the missing item in the progress notes and advised the nurse on the next shift, as is her practice.
PSW #S107 and #S108 were interviewed about the missing electric razor and they recalled doing a search for the missing item as well as advising the nurse in charge. The items have not been located.

In an interview on December 22, 2014, the DOC confirmed that "Missing Items Report" was not completed for either of the missing item. [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 the plan, policy, protocol, procedure, strategy or system related to the skin and wound program, the medication management system, and the procedure for residents' lost clothing and personal items is complied with, to be implemented voluntarily.***

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**WN #3: 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 comply with LTCHA, 2007 s. 15(2)(c) whereby the home, furnishings and equipment are not maintained in a safe condition and in a good state of repair.

The following observations were made during the course of the Resident Quality Inspection:

Room 11:
- bathroom sink has a 3" (3 inch) broken chipped piece, very rusted along the outside edge, rusted through with a big hole which poses a risk of resident injury.
- bathroom door is heavily scarred along the bottom 8", dark marks along the door edge approximately 12" below the door knob.
- drywall corner outside the bathroom door chipped and heavily scarred.

- linoleum floor in bedroom is old and discoloured, floor seam on wall is lifting.
- lower left wall scarred, white dresser legs chipped and wood missing, baseboard heater rusted and scarred.

Room 238:
- some wheelchair black marks and dry wall damage on contact walls in room.

Room 8:
- marks on walls and door frames, marks on tile floors especially at seams of tiles.

Room 4:
- left side bathroom wall has a large broken piece of drywall.
- bathroom wall on the bottom scarred.
- bathroom doors scarred, bottom foot of closet doors are scarred.
- bedroom door difficult to close seems to have swelled.

Room 5:
- floor seams cracked which posed a trip hazard, bathroom door scarred, chipped wood splintered, patched drywall beside toilet tank. - bathroom wall drywall scarred, bedroom door heavily scarred both sides.

Room:7
- 2" tear in flooring at the head of resident's bed near leg of dresser.
- large seam in the floor discoloured.
- corner near bathroom chipped plaster missing.
- bathroom door frame scarred, bedside table strapping chipped.
- chips in sink enamel.
- minor scarring on bathroom door frame.

Room 8:
- marks on walls and door frames, marks on tile floors especially at seams of tiles.

Room 248:
- marking visible on much of tile floor, tile lifting at seams and darker marks, few marks on walls.

Room 39:
Marks on walls.

Room 37:
- marks on tile floor especially along seam, rust marks along baseboard heater, marks on walls, 2 small holes in bathroom wall.

Room 16
- left lower wall at the entrance scarred, chipped and paint removed exposing corner bead.
- floor patched in front of the bed, bathroom sink has 3" chip on outer edge, enamel rusted which posed a risk of resident injury.

- grab bar beside the toilet rusted at one end, worn with white discolouration.
- flooring yellowed.

Room 200:
- some marks on walls, small marked area on tile floor.

Room 6:
- floor seam chipped, small tears.
- baseboard heater scarred.
- drywall beside bed side table chipped.
- rust coloured spots on the floor near entrance.
- bathroom door frame marked, black marks on the wall near bathroom.

Room 214:
- marks on tile floor in bathroom including gaps.

Room 35:
- marked areas of tile including gaps, marks on walls and chipped paint, also door frames.

Room 201:
- dark marks on tiled area beside toilet.

Room 14:
- electric extension cords taped along underneath the baseboard heater, tape is dirty and detached.
- multiple octopus extension cord with multiple plugs on shelf beneath bed side table.
- left wall heavily marked and scarred with small gouges along bottom.
- door frames heavily marked and scarred.
- closet doors scarred.
- flooring yellowed with bathroom doors chipped and heavily scarred.

Room 42:
- marking visible on much of tile floor, darker marks and tile lifting at seams which posed a trip hazard, few marks on walls.

Room 238:
- some wheelchair black marks and dry wall damage on contact walls in room.

Room 31:
- marked areas including tile lifting on bathroom floor.

Common Areas:
- activity room door frame damaged, trim coming off bottom of both entrance door frames.
- rusted worn over-bed table, legs rusting.
- wooden green chairs with scuffed chipped legs. [s. 15. (2) (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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10 s. 50(2)(b)(iv) whereby a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the health care record indicates that Resident #3 has multiple co-morbidities including several pressure ulcers that have been present for five months with complications.

"Weekly Wound Measurement Tool" forms were completed twice during five months for Resident #3. The home's policy "Wound and Skin Care Protocols" and the resident's Care Plan direct staff to document weekly wound monitoring and evaluation assessments.

On December 23, 2014, RPN #S125 and the DOC confirmed that wound assessments are not always completed as required. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the LTCHA 2007, s. 60(2) whereby the licensee does not respond to concerns or recommendations about the operation of the home within 10 days of receiving the advice to the Family Council, in writing.

During an interview on December 22, 2014, the President of the Family Council #F119 noted that the home responds to concerns raised by the Family Council, but she was not sure if all of the concerns received a written response within 10 days.

On December 22, 2014, the minutes of the Family Council meeting from September 9, 2014, were reviewed. The minutes reported that all members expressed their ongoing concerns about the difficulty of finding staff members between supper time and seven pm. The concerns were received by the Administrator on September 16, 2014, and a written response was provided on October 3, 2014.
The minutes from the meeting on November 11, 2014, reported that concerns were again raised about the difficulty of finding staff members between supper time and seven pm. The DOC responded verbally at the same meeting, but there was no written response received by the Council.

On December 23, 2014, the Administrator and the Activity Manager #S106 confirmed that the licensee does not respond to concerns or recommendations about the operation of the home to the Family Council, within 10 days, in writing. A new process is being developed to ensure that a written response is provided to Council within 10 days. [s. 60. (2)]

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the LTCHA 2007, s. 67 whereby the licensee does not consult regularly with the Family Council, and in any case at least every three months.

During an interview on December 22, 2014, the President of the Family Council #F119 noted that the licensee does not consult with the Council at least every three months.

On December 23, 2014, the Administrator and the Activity Manager #S106 confirmed that the licensee does not consult with the Family Council at least every three months. Plans are being developed to ensure that these meetings take place. [s. 67.]

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**WN #7: 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).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the LTCHA 2007, s. 85(3) whereby the licensee does not seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview on December 22, 2014, the President of the Family Council #F119 noted that the licensee provides the Council with the results of the satisfaction survey, but the licensee does not seek the advice of the Council in developing and carrying out the survey.

On December 23, 2014, the Activity Manager #S106 noted that the Resident Council provides input into the creation of the satisfaction survey, but she was not aware that the Family Council should also provide advice. [s. 85. (3)]

**WN #8: 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 comply with O. Reg. 79/10 s. 129(1)(a)(ii)whereby drugs were not stored in an area or a medication cart that is secure and locked.

On December 15, 2014, two prescribed treatments were observed unattended and unlocked on top of a Personal Support Worker's supply cart. Resident #42, a cognitively impaired resident, was observed wandering in the halls at the time.

On December 22, 2014, three prescribed treatments were observed unattended and unlocked on top of a Personal Support Worker's supply cart. Resident #42, a cognitively impaired resident, was observed wandering in the halls at the time.

Interviews with RN #S113 and RPN #S117 confirmed that prescribed topical treatment medications are to be locked in the medication room.
In an interview with the Director of Care on December 22, 2014, she confirmed that prescribed topical treatment medications are to be kept safely and securely locked at all times. [s. 129. (1) (a)] [s. 129. (1) (a)]

2. The licensee has failed to comply with O. Reg. 79/10, s.129(1)(b) whereby controlled substances were not stored in a separate, double-locked stationary cupboard in the locked area.

On December 19, 2014, Inspector #531 observed one vial of Lorazepam 4mg/ml stored in the fridge of the locked medication room in the Nursing #1 area. There were other emergency injectable medications visible in the fridge. The vial of Lorazepam was labeled with a sticker stating that the medication was to be refrigerated.
The fridge was not locked and as such, the controlled substance was not double-locked as per legislative requirements. [s. 129. (1) (b)]

**WN #9: 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 licensee has failed to comply with O. Reg. 79/10 s. 228.3. whereby the licensee does not ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Family Council on an ongoing basis.

During an interview on December 22, 2014, the President of the Family Council #F119 noted that the licensee does not ensure that improvements made through the quality improvement and utilization review system are communicated to the Family Council.

On December 23, 2014, the Administrator and the Activity Manager #S106 confirmed that the licensee does not communicate information to the Family Council about improvements made through the quality improvement and utilization review system on an ongoing basis. [s. 228. 3.]

**Issued on this 5th day of January, 2015**

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

**Original report signed by the inspector.**

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**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**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | BARBARA ROBINSON (572), ANANDRAJ NATARAJAN (573), SUSAN DONNAN (531), WENDY BROWN (602) |
| **Inspection No. / No de l'inspection :** | 2014_236572_0031 |
| **Log No. / Registre no:** | O-001363-14 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jan 2, 2015 |
| **Licensee / Titulaire de permis :** | CARVETH NURSING HOME LIMITED<br>375 JAMES STREET, GANANOQUE, ON, K7G-2Z1 |
| **LTC Home / Foyer de SLD :** | CARVETH CARE CENTRE<br>375 JAMES STREET, GANANOQUE, ON, K7G-2Z1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | |

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To CARVETH NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 9. Doors in a home

**Order / Ordre :**

In order to achieve compliance with O. Reg. 79/10 s. 9(1)1.1, the licensee will ensure that the newly installed lock on the door at the junction of Joyce Faye and Kingsley Earl unit halls is safely secured and monitored to restrict unsupervised access to the Veteran's Garden, a secure outside area.
In order to achieve compliance with O. Reg. 79/10 s. 9(2) the licensee will ensure that the home has a written policy that deals with when doors leading to a secure outside area (Veteran's Garden) must be unlocked or locked to permit or restrict unsupervised access to the garden area by residents.
In order to achieve compliance with O. Reg. 79/10 s. 9(1)2. the licensee will ensure the following:
a) All resident accessible doors leading to non-residential areas are equipped with functional locks to restrict unsupervised access to these areas by residents, and
b) All resident accessible doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

In addition, the license will implement a door management system to ensure that all locks on doors leading to non-residential areas are functional, and that doors are kept closed and locked as needed to restrict unsupervised access. All staff must be educated about this requirement which includes the need to immediately report any broken door locks. This education is to be documented.

**Grounds / Motifs :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1)1.1, whereby the licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
On December 15, 2014, during the initial tour of the building, Inspector #531 observed that a door leading to the Veteran's Garden, an outdoor enclosed

courtyard was unlocked and the area was unsupervised. The door is located at the junction of Joyce Faye and Kingsley Earl unit halls. There was a light plastic expandable gate in front of the door that was easily removed and the door opened. Inspector #572 also observed the open door shortly afterwards. Residents and family members walk along the hall frequently during the day.
On December 15, 2014, the DOC stated that the lock on the door has been broken since Friday, December 12, 2014, and that the home is waiting for a part to arrive to fix the door. She confirmed that the door is unsupervised and provides access to the courtyard which is also unsupervised in the winter. The lock was repaired and locked on December 19, 2014; it remained locked for the remainder of the RQI.

The licensee has failed to comply with O. Reg. 79/10 s. 9(2) whereby the licensee has failed to ensure that the home has a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.
On December 16, 2014 the DOC confirmed that the home does not have a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The licensee has failed to comply with O. Reg. 79/10, s. 9(1)2 whereby the licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and to ensure that those doors are kept closed and locked when they are not being supervised by staff.
The following observations present a pattern of potential risk to residents in the home, particularly for those residents who exhibit behaviours such as wandering and/or exit-seeking:
#1: Doors to the kitchen which are accessible from the service hall- On December 15, 2014, during the initial tour of the building, Inspector #531 observed that the kitchen doors were open, unlocked, and that the area was unsupervised. The kitchen contains a stove, dishwasher, large sinks and various utensils used for food preparation. Inspector #572 also observed the open doors and unsupervised kitchen shortly afterwards, and the DOC was informed of the risk to residents from the open and unsupervised doors along the service hall. She noted that there is a Beltrac belt with wall mount stretched across the

service hallway. It did not prevent three residents from entering the service hallway; two residents were redirected as they attempted to enter rooms in the area. Inspector #572 noted that by noon, the kitchen door was closed but remained unlocked and the area was unsupervised.
#2: Doors to a servery which are accessible from the service hall, a residents' lounge and a residents' dining room- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the doors to the server were open and that the area was unsupervised. There was no lock on the doors. The server contains food storage areas such as a fridge and several hot plates which are turned off when staff are not in the area. Inspector #572 also observed the open doors and unsupervised area shortly afterwards. Dietary staff reported that the room is not kept locked as it is the location of any food preparation required for residents in the evening and night shifts. There were numerous family members and residents in the dining room and lounge throughout the day.
#3: Doors to the laundry area which is accessible from the service hall- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the laundry doors were open, unlocked, and that the area was unsupervised. The laundry area contains large industrial washers and dryers as well as soap. By noon the door was locked.
#4: East Wing servery which is accessible from a hall in the home and a residents' dining room- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the East Wing servery door was open, unlocked, and that the area was unsupervised. The servery contains food storage areas such as a fridge, an ice machine and several hot plates which are turned off when staff are not in the area. Inspector #572 also observed the open door and unsupervised area shortly afterwards. By noon the door was locked.
#5: Storage room called “Laundry Room” which is accessible from a hall in Joyce Faye Terrace- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the Laundry Room door was open, unlocked, and that the area was unsupervised. The room contains a washer and dryer, as well as numerous large tables and other items stacked against the walls. Inspector #572 also observed the open door and unsupervised area shortly afterwards. The room remained unlocked and unsupervised.
#6: Storage Room which is accessible from a hall in the Earl Kingsley Wing- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the Storage Room door was open, unlocked, and that the area was unsupervised. The room is full of wheelchairs and mobility aids. Inspector #572 also observed the open door and unsupervised area shortly afterwards. The room remained unlocked and unsupervised.

#7: West Wing storage room which is accessible from a hall in the wing- On December 15, 2014 during the initial tour of the building, Inspector #531 observed that the Storage Room door was open, unlocked, and that the area was unsupervised. The room contains restraints, medical supplies, soaps and sprays. Inspector #572 also observed the open door and unsupervised area shortly afterwards. The room remained unlocked and unsupervised.

On December 15, 2014, the DOC was notified of the list of areas where doors to non-residential areas were open, unlocked, and unsupervised. She confirmed that these areas should be closed and locked when unsupervised.
On December 19, 2014 all doors to non-residential areas were observed to be closed and locked unless supervised. They remained closed and locked unless supervised for the remainder of the RQI. (572)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 30, 2015

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

| | |
|---|---|
| À l'attention du registraire<br>Commission d'appel et de révision des services de santé<br>151, rue Bloor Ouest, 9e étage<br>Toronto (Ontario) M5S 2T5 | Directeur<br>a/s Coordinateur des appels<br>Direction de l'amélioration de la performance et de la conformité<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Ontario, ON<br>M5S-2B1<br>Fax: 416-327-7603 |

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 2nd day of January, 2015**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Barbara Robinson

**Service Area Office /**
**Bureau régional de services :** Ottawa Service Area Office