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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 28, 2018	2018_748723_0001	008090-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

ADELFA ROBLES (723), LYNDA BROWN (111), MELISSA HAMILTON (693), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 9, 10, 11, 12, 13, 16, 17, 18, 19, and 20, 2018.

The following Critical Incident System (CIS) report intake related to falls in the home were completed during this inspection:
Log #000231-18

Inspector Saran Daniel-Dodd (#116) attended this inspection for the adherence process.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Dietary and Environmental Operations Partner (DEOP), Director of Resident Programs and Admission (DRPA), Environmental Services Manager (ESM), Interim Maintenance (IM), Recreation Aide (RA), Registered Dietitian (RD), Cook, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Residents, Substitute Decision Makers (SDM), President of the Residents' Council, and Family Council Coordinator.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal services, medication administration and storage area, staff and resident interactions, provision of care, conducted reviews of health records, and CIS logs, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 71. (4)	CO #001	2017_414110_0012	604

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM had been provided an opportunity to participate fully in the development and implementation of the plan of care.

During stage one of Resident Quality Inspection (RQI), resident #006's census record review identified the resident had a change in condition.

A review of progress notes for resident #006, indicated:
-On an identified time and date, the resident had a health concern.
-Nine days later, the resident had health concern.
-Two days later, the resident reported having health concern and was administered medication with good effect.
-Two days later, the resident complained of an identified health concern and was administered another identified medication with good effect.
-The next day, the resident had health concern and was administered medication. The resident was reported to have an identified health concern and was sent to the hospital.

For the above incidents the inspector was unable to find evidence that the SDM was informed of the changes of health status and provided an opportunity to participate in

providing input into the residents care.

An interview with Registered Practical Nurse (RPN) by Inspector #111, stated the expectation was to notify the SDM's when the resident has a change in condition. The RPN indicated to Inspector #111 that they had not contacted the SDM on identified dates, despite the resident having changes in condition.

An interview with Director of Care (DOC) by Inspector #111, the DOC stated that the expectation was that the registered nursing staff notify the SDM of residents whenever the resident has a change in condition.

2. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report on an identified date, to the Ministry of Health and Long Term Care (MOHLTC) Director, for an incident which occurred on an identified date. The CIS indicated resident #021, had a fall and was transferred to hospital for further assessment. The CIS also indicated that resident #021, sustained an injury and returned to the home the next day.

A review of resident #021's written plan of care indicated that the resident was at risk for falls.

Observations were carried out by Inspector #723, for resident #021, on identified dates and times and revealed that resident #021, did not have an identified intervention on their mobility aid to prevent falls as specified in the written plan of care.

An interview with Personal Support Worker (PSW) by Inspector #723, indicated that they were not aware resident #021, was supposed to have the identified intervention on their mobility aid when in use. The PSW reviewed resident #021's written plan of care and acknowledged that resident #021, should had the identified intervention on their mobility aid when in use as specified in the written plan of care.

An interview was conducted with Registered Nurse (RN) by Inspector #723, and revealed that the RN was not aware that resident #021, was supposed to use the identified intervention on their mobility aid. The RN reviewed resident #021's written plan of care and acknowledged that resident #021, should have the identified intervention on their mobility aid when in use as specified in the written plan of care.

An interview was carried out with the DOC by Inspector #723, the DOC reviewed resident #021's written plan of care and stated that the care set out in the plan for resident #021, was not provided as specified in the plan when resident #021, did not have the identified intervention on their mobility aid when in use.

3. Resident #006, was triggered from stage one of the RQI related to poor food quality.

A review of the written care plan for resident #006, indicated the resident was at high nutritional risk. Interventions indicated the resident was to have a special dietary requirement when served with identified foods.

Observations were carried out for resident #006, on identified dates and time by Inspector #111, and observed that resident was served meals that did not satisfy the resident's special dietary requirement when served with the identified foods.

An interview with resident #006, was carried out by Inspector #111, and the resident indicated that they were usually served with foods that do not satisfy their special dietary requirements.

An interview with PSW was carried by Inspector #111, the PSW indicated they were unaware that resident #006's written plan of care stated that the resident is to have a special dietary requirement when served with identified foods.

An interview with the Registered Dietitian (RD) was carried out by Inspector #111, the RD confirmed that resident #006, was to have a special dietary requirement when served with identified foods. The RD indicated no awareness that the resident was being served foods that do not satisfy their dietary requirement.

4. The licensee had failed to ensure the resident was reassessed and the plan of care was reviewed and revised at least every six months, and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #006, triggered from stage one of the RQI related to a change of condition through census review. Census review indicated resident was admitted to the hospital on an identified date.

A review of the progress notes for resident #006, was carried out for an identified month

which indicated that on an identified dates the resident had an identified health change. The resident was then transferred to the hospital the next day and returned to the home after four days with an identified diagnosis.

A review of the Electronic Medication Administration Record (EMAR) for resident #006, revealed resident #006 was prescribed a medication to relieve a medical condition. The resident also had a medical directive for a medical condition that was not utilized by the home in an identified month.

A review of resident #006's electronic records completed on admission indicated that resident #006, was on medication to relieve a medical condition. There was no other documentation to indicate a follow up with regards to resident's condition upon return from the hospital.

A review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for resident #006, was completed on an identified date, resident was documented as having incontinence and no change in condition.

A review of the current written care plan with an identified date for resident #006, indicated under the focus "Toileting" identified resident required assistance related to impaired mobility related to an identified diagnosis and an identified nutritional regime.

There was no indication that resident #006, was reassessed or the plan of care was reviewed or revised when the resident's care needs changed related to a change in health condition. The resident was not reassessed upon return from hospital for an identified diagnosis and no other interventions was considered to prevent a recurrence. The assessments completed were also not based on the resident current needs.

An interview with RN #104, was carried out on an identified date, by Inspector #111, indicated that PSW's are to document residents toileting needs in Point of Care (POC). The RN indicated the night RN then reviews the POC documentation to determine which residents require further assessments.

An interview with the DOC was carried out on an identified date by Inspector #111, indicated the expectation when a resident returns from hospital with an identified medical condition, is to complete a referral to the RD for dietary interventions, notify the physician for possible medication to be prescribed related to changes in health condition, registered nursing staff to complete an assessment electronically and update the written

plan of care. The DOC confirmed that resident #006, had not been reassessed and the plan of care reviewed and revised when the resident returned from hospital with change of condition.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that;
-the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care,
-the care set out in the plan of care is provided to the resident as specified in the plan,
-the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee had failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Resident #002, was triggered from stage one of the RQI related to a fall in the last 30 days triggered through MDS Most Recent [MR].

Observations were carried out on identified dates at different times of the day and each time Inspector #693, observed an identified bed equipment was placed under the resident's mattress sitting on top of the bed frame.

Interviews were carried out with PSW #109, #113, #115, and RN #105, on an identified date. PSWs #109 and #113, and RN #105, stated to Inspector #693, that the identified bed equipment should be placed underneath the mattress of the bed. PSW #115, indicated that the identified bed equipment is to be placed on top of the mattress underneath the top sheet.

A review of the manufacturer's instructions of the identified bed equipment, indicated that the identified bed equipment are to be placed across the bed, directly on top of the mattress, under the sheet, with the connector and cord exiting out the side.

An interview with the DOC was carried out on an identified date, indicated the identified bed equipment is to be placed on top of the mattress and under the sheets. Inspector #693, informed the DOC of their observation and the DOC confirmed that the identified bed equipment should be placed directly under the sheets on top of the mattress. Inspector #693, reviewed the manufacturer's setup instructions for the identified bed equipment and the DOC confirmed that the manufacturer's instructions were not followed since the identified bed equipment was placed under the mattress.

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 staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

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 had failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living that was included in a resident's plan of care has been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

Resident #006, triggered in stage one of the RQI for minimizing of restraint through resident observation. Resident #006, was observed by Inspector #693, during stage one of the RQI with a potential restraint or PASD while the resident was in bed.

On an identified date and time Inspector #111, carried out an observation for resident #006, the resident was observed to be in bed with potential restraint or PASD.

An interview was conducted with resident #006, on an identified date by Inspector #111. The resident indicated the staff use the PASD to keep them safe in the bed as the resident had a medical diagnosis and is used to reposition self in bed.

A review of the health record for resident #006, had no physician order regarding the use of PASD or to indicate whether they were used as a restraint or PASD.

Interview with RPN #111, and RN #104, by Inspector #111, on an identified date both indicated whenever any resident uses restraints or PASD, a doctor's order is to be obtained and kept in the resident's chart. They both confirmed that resident #006, used PASD while in bed for repositioning purposes and was considered a PASD. Both the RN and RPN indicated the physician order should have been in place but confirmed there was no physician's order for the use of the PASD for resident #006.

Interview with the DOC on an identified date by Inspector #111, indicated the expectation from registered nursing staff is when a resident is assessed and determined to require the use of PASD, the registered nursing staff would be required to obtain an order from the physician. The DOC confirmed there was no physician's order obtained regarding the use of PASD for resident #006.

2. Resident #001, triggered through stage one of the RQI for minimizing of restraint though a resident observation. During stage one of the RQI, Inspector #693, observed

that resident #001, had a potential restraint or PASD while on the bed.

On an identified dates, Inspector #693 carried out observations and found that the resident had potential restraint or PASD while on bed.

A review of resident #001's electronic chart on Point Click Care (PCC) and resident's paper chart, written plan of care with an identified date and physician's orders did not show evidence to indicate resident #001, utilized restraints or PASD.

An interview with PSW #107 was carried out on an identified date, indicated resident #001 utilized PASD when in bed for bed mobility.

An interview with RPN #119 carried out on an identified date indicated resident #001, utilized PASD when in bed for bed mobility. The RPN confirmed that there was no physician order for the use of the PASD for resident #001.

An interview with the DOC carried out on an identified date indicated to Inspector #693, that resident #001, utilized PASD. The DOC and Inspector reviewed resident #001's physician orders and the DOC acknowledged that there was no PASD order for resident #001.

3. Resident #008, was triggered through stage one of the RQI for minimizing of restraint triggered though resident observation. During stage one resident #008, was observed to have a potential restraint and or PASD.

On an identified date and time Inspector #723, conducted an observation for resident #008. The resident was in bed with the potential restraint/PASD observed.

A review of resident #008's paper chart and PCC electronic chart, along with physician's orders were carried out and Inspector #723, did not find a physician order for resident #008's use of restraint or PASD.

An interview with PSW #113, was carried out on an identified date, confirmed that resident #008, utilized PASD to reposition themselves when on the bed.

An interview with RN #104, was carried out on an identified date, stated that resident #008, used PASD and a physician order should be obtained when a resident uses PASD. The RN acknowledge that upon review of the physicians orders, there was no

written physician order for resident #008, related to the use of PASD.

An interview with the DOC was carried out on an identified date stated that when a resident is utilizing PASD the registered staff are expected to obtain an order from the physician. The DOC reviewed the PCC physician orders with Inspector #723, and acknowledged that there was no physician order for resident #008's use of PASD.

4. The licensee had failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living that was included in the resident's plan of care had 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.

Resident #006, was observed by Inspector #693, during stage one of the RQI with potential restraints or PASD while the resident was in bed. A follow-up observation of resident #006's was conducted on an identified date and time and it was observed that resident #006, was on bed with the potential restraints or PASD.

Interviews were conducted with RPN #111, and RN #104, by Inspector #111 on an identified date both indicated whenever a resident uses restraints or PASD, a paper consent is to be completed and placed in front of the resident's chart. The registered staff both confirmed that resident #006, utilized PASD while in bed for repositioning purposes and indicated there should have been a paper copy of the consent form completed. The registered staff acknowledged there was no documented evidence to indicate a consent was obtained.

An interview was carried out with the DOC on an identified date by Inspector #111, indicated the expectation of registered nursing staff was that if the resident is assessed and determined to require the PASD, the registered nursing staff would also be required to obtain consent from the resident or the resident's SDM. The DOC confirmed that there was no consent in place for resident #006, for the use of PASD.

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 use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations
-the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

The licensee had failed to ensure that the resident was offered a minimum of three meals daily.

On an identified date and time Inspector #693, and #723, with Inspector #604, carried out the mandatory meal observation at lunch in the main dining room of the home. Inspector #693, and #723, spoke with PSW #102, and inquired if there were any residents on tray service for the lunch meal and the PSW stated resident #013, was to receive a tray.

During the course of the lunch meal service the following observations were made for resident #013:

-At an identified time Inspector #693, observed resident #013, in bed; resident #013 stated that they had not yet been offered lunch.
-At an identified time Inspector #693, and #723, observed resident #013, was still in bed and the resident stated that they had not yet been offered lunch or seen the show plates.
-At an identified time Inspector #723, observed resident #013, and asked if lunch was offered resident #013, responded "no".
-At an identified time Inspector #693, observed resident #013, who was in bed and not yet offered lunch and the resident stated that they were hungry.

Resident #013, was also observed by Inspector #693, at an identified times on all occasions resident #013, stated that lunch had not been offered.

Inspector #723, observed resident #013, at an identified times, resident stated that lunch had not been offered.

An interview was conducted with PSW #102, on an identified date and time stated that the home’s process for tray service was that the PSWs would have a list of resident names requesting for tray service and their meal preference prior to start of meal service. The PSWs would then inform the cook to set aside their meals. Any meal refusals would be reported by the PSWs to the registered staff for them to document electronically in the POC. The PSW indicated that they were assigned to resident #013, and offered resident lunch twice and on both times the resident refused lunch. The PSW further stated that they were not able to recall the times they went into the resident's room to offer lunch and failed to inform the registered staff about resident's meal refusals but had it documented on the POC. The PSW also stated that resident is competent to make choices and reliable when asked questions.

An interview was carried out with RPN #103, on an identified date and time. They stated that the home’s process is for trays to be delivered after meals so residents can be monitored in their rooms. They stated that the PSWs are responsible for asking residents their choice for meals and informing the registered staff of any meal refusals.

RPN #103, stated they were familiar with resident #013, and that the resident is capable of making day to day decisions and giving yes or no answers. RPN #103, checked the PCC and confirmed that resident did not receive lunch on an identified date and there was no documentation that resident refused lunch on that day.

An interview was carried out with RN #104, on an identified date and time they stated

that the home's process for residents having trays in their rooms is for the PSWs to go to the resident's room and offer show plates, document choices, and inform the cook. Once dining service was completed in the main dining room the PSWs deliver the trays and supervise the residents in their rooms. The RN stated that they were not informed that resident #013, refused lunch meal tray on an identified date, and was unable to recall if the resident received a tray for lunch. The RN checked the documentation in PCC and POC and stated that there was no documentation of the refusal of lunch by resident #013, in either system.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident was offered a minimum of three meals daily, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

The licensee had failed to ensure that all food and fluids in the food production system where prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

Resident #006, was triggered through stage one of the RQI for poor food quality through the resident interview. Resident #006, had indicated to Inspector #724, that the meals are served in inappropriate temperature and resident has trouble eating the meal.

An interview was conducted with resident #006, on an identified date and time by

Inspector #111, and the resident indicated the resident had just received their breakfast tray and the meal was served in inappropriate temperature. The tray service was provided over two hours past the breakfast time period and the resident had received food that was not served using methods which preserved food quality.

An interview was carried out with the DOC on an identified date by Inspector #111, indicated the expectation around providing residents with tray service was the dietary staff prepares the tray for the identified resident as per the resident's food choices. The PSW then delivers the meal tray to the assigned resident ensuring appropriate temperatures and are served to residents after the main dining room service is completed. DOC indicated the PSWs are to deliver meal trays to assigned residents during the meal service if there is time available and sometimes meal trays are provided to assigned residents prior to the supper meal service. The DOC was made aware that on an identified date resident #006, had received meal tray that was served in inappropriate temperature resulting to resident #006, not eating their meal.

2. On an identified date and time Inspector #693, and #723, with Inspector #604, carried out the mandatory meal observation at lunch in the main dining room of the home

Inspector #693, and # 723, spoke with PSW #109, and inquired if there were any residents on tray service for the lunch meal and the PSW stated resident #006, and #013, was to receive a tray today.

During the course of the lunch meal observation Inspector #693, and Inspector #723, observed two plated meals placed with beige lids on the left side of the servery metal countertop in main dining room at room temperature at an identified time.
Inspector #693, checked the two plated meals and one meal plate was the cold plate which consisted of two devilled eggs, cold pasta salad, and beets, the other plate was the hot meal which consisted of a corn and a riblet sandwich. At an identified time, PSW #107, was observed to be to checking the two meals placed with beige lids at the servery metal countertop in main dining room. Inspector #693, intervened and asked PSW #107, if they were going to serve the two meals that were on the metal countertop, the PSW stated that each plate was for resident #006, and #013. The Inspector inquired if it was appropriate to serve the cold plates which have been sitting on the countertop for an hour and ten minutes PSW #107, checked with kitchen staff if this was safe and stated to Inspector that this was not safe or appropriate to serve them as the cold plate meal consisted of mayonnaise and egg. At an identified time PSW #102, attempted to serve a tray that contained riblet sandwich which was sitting on the countertop and Inspector

#693, intervened and asked PSW #102, if they intended to serve the food to a resident, the PSW stated that were going to serve the plate. Inspector #723, asked if this was appropriate to serve the hot meal which consisted of a corn and a riblet sandwich which had been sitting on the countertop for one hour and ten minutes and PSW stated that it was not appropriate.

An interview was carried out with the Cook on an identified date, stated that the two meal plates that were sitting on the server were prepared before an identified time and had been sitting there from that time. They stated this was not an appropriate way to store food and they did not know of a place where they could store cold trays on cold temperatures and hot trays on hot temperatures to preserve the quality of the food. The Cook stated that it would not be appropriate to serve trays sitting at room temperature for over an hour.

Inspector #693 reviewed the home's policy titled "Dining-Tray Service; VII-I-10.60" last revised on an identified date. The policy stated that the dietary team will ensure food is served at the adequate temperature (hot food above 60 ºC and cold food below 4 ºC).

An interview was carried out with the Dietary and Environmental Operations Partner (DEOP) #105, on an identified date stated that the home's policy is to store all trays at an appropriate temperature to preserve the food and taste and to keep the trays covered. They stated that hot foods should be stored at above 60 ºC and cold foods should be stored at below 4 ºC to maintain food quality and safety. Inspector #693, informed the DEOP of their lunch meal observation on an identified date related to the tray service meals and the DEOP acknowledged that the two trays that were sitting at room temperature for at least one hour and ten minutes were not stored appropriately.

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 food and fluids in the food production system where prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the staff received training on all Acts, regulations, policies of the Ministry, and similar documents, including policies of the licensee that are relevant to the person's responsibilities prior to performing their responsibilities.

The mandatory medication observation was conducted on an identified date by Inspector #723, and #116. A subsequent interview was carried out after the medication observation with RPN #111, who stated that they were not aware of the home's policies related to medication management and reporting medication incidences.

An interview was conducted on an identified date with the DOC indicated that registered staffs are required to complete their mandatory education on the home's policies and trainings online using the home's online portal prior to starting on the floor. The DOC stated that prior to working in the unit, registered staff receives orientation and trainings from their mentor. The mentor will review the home's policies to the registered staff. The orientation and education and or training records are kept with the Human Resource (HR).

Inspector #604, requested RPN #111's HR files, which indicated that RPN #111, was hired on an identified date. Upon review of the file the inspector was unable to find a completed education checklist for RPN #111. The inspector expanded the sample to two more newly hired registered staffs. Inspector #116, reviewed the two new registered staff HR files for RPN #129, and RN#130.

RPN #129, was hired on an identified date and an incomplete orientation checklist was provided by the DOC related to medication management/administration policies of the home. RN #130, was hired on an identified date with no education checklist found related to medication management/administration policies of the home.

A follow up interview was conducted on an identified date with the DOC who stated they did not recall RPN #111, receiving education/training on the home's medication management system and policies and also stated that RPN #111, did not have a record of their orientation checklist. The DOC stated RPN #129, and RN #130, were new hires and their orientation check lists were not found for both staffs.

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 staff received training on all Acts, regulations, policies of the Ministry, and similar documents, including policies of the licensee that are relevant to the person's responsibilities prior to performing their responsibilities, to be implemented voluntarily.

WN #7: 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 :

The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and that was secured and locked.

As part of the mandatory Medication Administration Inspection Protocol (IP), Inspector #693, reviewed the home's second medication incident for an identified period. On an identified date and time RPN #119, reported that a medication incident had occurred involving resident #011. The incident report indicated the resident self-administered two of their identified medications. The RPN reported that the resident usually takes the identified medications on their own and return the identified medications to the nurse after use. On an identified date the two identified medications were left on dining table and co-resident #004, found one of the identified medication and the other identified medication was missing and not found. The report did not indicate if the physician or family was notified of the incident when the identified medications were left unattended in the dining table and the one of the identified medication went missing.

An interview was carried out with RPN #119, on an identified date and time, stated that on an identified date they left the two identified medications out of the medication cart with resident #011, in the main dining room. The RPN acknowledged that one of the identified medication went missing after it was left with resident #011, and the medications should have been securely stored in the medication cart after administering the medication.

An interview was carried out with the DOC on an identified date stated that it was the home's policy for the registered staff to ensure that medications are locked after use in the medication cart. The DOC stated that for resident #011, the medications should not have been left unattended and acknowledged that one of the identified medication went missing for resident #011, and this was because the medication was not securely stored.

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and that is secure and locked, to be implemented voluntarily.

WN #8: 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 :

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

As part of the mandatory Medication Administration IP Inspector #693, reviewed the home's most recent medication incident. On an identified date and time RPN #119, reported that a medication incident had occurred involving resident #011. The incident report indicated the resident self-administered their two identified medications during an identified meal as the resident usually takes them after eating, and the resident would return the two identified medication to the nurse. On an identified date, the two identified medications were left on dining table and co resident found one of the identified medication and the other medication went missing.

On an identified date and time Inspector #693, and #604, carried out medication administration observation with RPN #111, for resident #011's medication pass. Once RPN #111, reconciled all the medication using the EMAR record and the medication strip packages the RPN brought the medications to resident #011, who was sitting in the dining room. The resident took the medications and the RPN placed the two identified

medications on the table in front of resident #011. The resident proceeded to self-administer the two identified medications independently with the RPN across the table.

An interview was carried out with RPN #111, on an identified date stated that when administering medications the home's policy is to follow the eight rights of medication administration, verify the order in EMAR to ensure accuracy of medication administration. The RPN stated that resident #011, self-administered the two identified medications and indicated that there was no information on the EMAR indicating self-administration and there is no physician's order indicating resident is able to self-administer the two identified medications.

An interview was carried out with RPN #119, on an identified date stated that on an identified date resident #011, self-administered their two identified medications and acknowledged that there was no physician order for self-administration of medication for the resident.

An interview was carried out with the DOC on an identified date stated that in order for a resident to self-medicate their medications there must be a physician order. Inspector #693, reviewed the medication incident report from an identified date involving resident #011, and also informed the DOC of the medication observation carried out on an identified date. The DOC acknowledged that resident #011, did not have a self –administer order from the physician to self-administer their medications.

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 no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Resident #006, triggered through stage one of the RQI for hospitalization through the census record review.

Inspector #111, carried out a review of resident #006's medical directives on an identified date and discovered a medication incident as follows: resident #006, had medical directives signed upon admission on an identified date which did not include the use of an identified medication which were signed as checked by two RPN's #123, and #124. A review of the EMAR indicated the medical directive for an identified medication was transcribed into the EMAR despite not having a physician's order and was noted to be

administered on an identified dates by the nursing staff.

An interview with the DOC was carried out on an identified date by Inspector #111. The DOC indicated the expectation with physician prescribed medical directives, is for two registered nursing staff to check the physician's orders and then transcribe the orders onto the EMAR. The DOC confirmed the medical directive for resident #006, signed on an identified date and acknowledged the use of an identified medication that was not prescribed. The DOC confirmed the medical directive for the identified medication was transcribed on the EMAR and administered on identified dates. The DOC indicated that they were unaware of the medication incident until it was brought to the attention of the home by Inspector #111.

2. A review of the home's quarterly medication incidence revealed that the home had two medication incidences on an identified period. As part of the mandatory Medication Administration IP, Inspector #723, reviewed the first medication incident which occurred on an identified date involving resident #004, and Inspector #693, reviewed the home's second medication incident which occurred on an identified date involving resident #011.

As part of the mandatory Medication Administration IP, Inspector #693, reviewed the home's second medication incident for an identified period. On an identified date and time RPN #119, reported that a medication incident had occurred involving resident #011. The incident report indicated the resident self-administered their two identified medications at an identified meal service and the two identified medications were left on the dining table in front of resident #011. On an identified date the two identified medications were left on dining table and co-resident #004, found one of the identified medication and the other identified medication was missing and not found. The report did not indicate if the physician or family was notified of the incident when the two identified medications were left unattended in the dining table and one of the identified medication went missing.

An interview with RPN #119, was carried out on an identified date. The RPN stated that the home's expectation was that when a medication error occurs the attending physician is to be notified. The RPN was able to recall the incident as indicated above and categorized the incident as a medication error as the identified medication was never found and stated that they documented the medication error on an incident report and acknowledged that they did not inform resident #011's attending physician.

An interview with the DOC was carried out on an identified date and stated that all

medication incidents should be reported to the resident's attending physician. The DOC and Inspector # 693, reviewed the incident as indicated above involving resident #011, which occurred on an identified date. The DOC confirmed the attending physician was not informed of the medication incident as one of the identified medication was never found.

3. Inspector #723, reviewed the home's medication incidence record and noted that on an identified date a second medication incident form was completed for a medication error involving resident #004, and was reported to the DOC on an identified date by the evening shift RPN. The incident report stated the family had not approved the use of an identified medication prescribed for resident #004, and the medication was to be on hold.

A review of resident #004's EMAR records for an identified month was carried out and revealed that on an identified date and time the identified medication was signed off as administered by RPN #128.

A review of resident #004's progress notes was reviewed from an identified dates and did not show evidence that the prescribing physician was notified that the identified medication was administered and the above medication incident had occurred.

An interview with RPN #128, who administered the identified medication to resident #004, on an identified date was carried out by Inspector #723. The RPN stated that the home's expectation was that medication incidents are to be reported to the prescribing physician. The RPN acknowledged that the medication incident as indicated above involving resident #004, was not communicated to the prescribing physician.

An interview with the DOC was carried out on an identified date confirmed that the home's policy was that the prescribing physician should be notified for any medication incidences. The DOC confirmed that the medication incident involving resident #004, which occurred on an identified date was not reported to the prescribing physician.

4. A review of the health care record for resident #006, on an identified date by Inspector #111, discovered a medication incident as follows: resident #006, had medical directives signed upon admission which did not include the use of an identified medication. The medical directives were signed as checked by two RPNs (#123 & #124). Review of the EMAR indicated the medical directive for the identified medication was transcribed despite no physician order and was administered on three identified dates. Review of the health care record on an identified date indicated no documented evidence of the

medication incident or to indicate what actions were taken to assess the resident.

Interview with DOC on an identified date by Inspector #111, indicated the expectation with physician prescribed medical directives, is for two registered nursing staff to check the physician orders and then transcribe the orders onto the EMAR. The DOC confirmed the medical directive for resident #006, that was signed on an identified date by the physician and checked by two RPNs did not include the use of an identified medication. The DOC confirmed the medical directive for the identified medication was transcribed on the EMAR and administered on three identified dates. Interview with the DOC on an identified date by Inspector #111, indicated they had not yet completed the medication incident that was reported to the DOC on an identified date. The DOC also confirmed that they had not reported the incident to the resident, the resident's SDM, the physician/ Medical Director but did speak to the pharmacy consultant.

The licensee failed to ensure that a medication incident involving resident #006, was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, the Medical Director and the prescriber of the drug.

5. The licensee had failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary and a written record is kept of everything required.

As part of the mandatory Medication Administration IP Inspector #693 reviewed the home’s second medication incident. On an identified date and time RPN #119, reported that a medication incident had occurred involving resident #011.

The incident report indicated the resident self-administered their two identified medications at an identified meal service and the two identified medications were left on the dining table in front of resident #011. The RPN reported that the resident self-administered the two identified medications and returned the two identified medications to the nurse after use. On an identified date the two identified medications were left on dining table and co- resident #004 found one of the identified medication and the other identified medication was missing and not found.

A review of the home’s documented medication incident, revealed that there was no documented corrective action plan and analysis conducted for the medication incident related to the identified medications that were left unattended in the dining table.

An interview with the DOC was carried out on an identified date stated that the incident from an identified date was considered a medication incident and confirmed that an analysis of this medication incident was not carried out.

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
-every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider
-all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary and a written record is kept of everything required, to be implemented voluntarily.

WN #10: 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee had failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming.

Resident #009, triggered through stage one of RQI for unclean/ungroomed through a resident observation. In stage one the resident was observed to be ungroomed.

A review of resident #009's current written plan of care with an identified date indicated under focus "Hygiene" required assistance related to impaired mobility. Interventions stated assistance with grooming on bath days and as needed.

An interview was carried out with resident #009, on an identified date by Inspector #111, indicated the resident groomed on their own with no staff assistance and had an identified personal preference related to grooming.

Interviews with PSW #122 and RPN #116 by Inspector #111 on an identified date, stated resident #009 had an identified personal preference related to grooming, and further indicated the plan of care did not reflect the identified personal preference.

WN #11: 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 :

The licensee had failed to ensure that the licensee responded in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #693, reviewed the Residents' Council meeting minutes for an identified period and the following concerns were brought by the Residents' Council to the home:

On an identified month:
-concerns related to short staffing and replacement of furniture after recreational activities. No written response or action was taken by the home.

On an identified month:
-concerns related to staffs delaying breakfast and not enough phones for PSWs. No written response or action was taken by the home.

An interview was conducted with the RCP resident #012, on an identified date and time by Inspector #693, and Inspector #604, attended the meeting. The RCP stated the home completes an identified form for the concerns brought to the home by the Council and the RCP receives a reply in writing within ten days. The RCP reviewed the concerns list for an identified period and acknowledged that the home did not address the concerns within ten days in writing.

An interview was carried out with the DRPA on an identified date stated that there is an identified form that is completed at the Council meetings and is provided to department managers. Inspector #693, and the DRPA reviewed the Residents' Council meeting concerns brought to the home for an identified period. The DRPA stated that there was no identified form completed for the RCs concerns for an identified period and that the home did not respond to any of the Councils concerns within ten days in writing.

An interview was carried out with the ED #120, on an identified date by Inspector #693, and Inspector #604, stated that it would be the responsibility of the DRPA to ensure a response is in writing and received by the Residents' Council within ten days and that there should be an identified form completed from the licensee to address the concerns of the Council. Inspector # 693, and Interim ED reviewed minutes from the Residents' Council for an identified period. The interim ED acknowledged that the home did not respond within ten days in writing to the Council related to their concerns.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

The licensee had failed to ensure that as a part of the organized program of laundry services under clause 15(1) (b) of the Act, every licensee of a long-term care home shall ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

Resident #006, and #009, triggered through stage one of RQI for missing personal item through a resident interview.
-In stage one resident #006, stated when they first moved into the home on an identified date, they were missing an identified personal item and had informed the staff. The resident stated that the identified personal item was still missing.
-In stage one resident #009, stated they had lost a personal item which was labelled and reported to the staff but was never located. Resident #009, reported to Inspector #116, that they were missing an identified personal items approximately a month ago and that they were labelled. The resident indicated the lost items were reported missing to the nursing staff but the items were never located.

A review of the home's policy VII-C.10.12 titled "Missing Clothing and Items", with an identified revision date, indicated under procedure that the PSW will ensure that the missing items form is made readily available to residents/families in each resident home area, assist in completing the form, conduct a search of resident room and area for lost

clothing, and report the lost item by forwarding the form to the Environmental Services department if the item is not found. The Environmental Services Manager (ESM) will follow up on a monthly basis on all lost items not resolved and file a copy of the completed Missing Laundry and Items form.

A review of resident #006, progress notes on an identified period and a review of resident #009's progress notes on an identified period was carried out by Inspector #111, and did not find evidence of the residents reporting any missing personal items to the nursing staff.

An interview was conducted with PSW #108, on an identified date, by Inspector #111, indicated the process for lost personal items included checking the laundry room and to check other resident rooms for the lost personal items. The PSW indicated if they were unable to locate the item, they would report verbally to next shift to check and report to the DOC. The PSW indicated no awareness of any documentation requirements related to residents with lost personal items. The PSW was not aware of resident #006, or resident #009, having any lost personal items.

An interview was carried out with ESM #110, on an identified date by Inspector #111, indicated it is usually the families or staff that report any lost personal items, but sometimes, the resident's themselves will report it to the ESM. The ESM indicated the process for dealing with lost personal items include checking the rack in the laundry room that is kept with unlabelled resident's items to see if they can locate the item and then pass on verbally to other nursing staff to check other resident rooms for the lost personal item and then pass on to the other Environmental Service (ES) staff. The ESM indicated there was no documentation kept for missing personal items in a form in order to follow up on a monthly basis on all lost items not resolved.

An Interview was conducted with the DOC on an identified date by Inspector #111, indicated the expectation when a resident and/or family member reports a lost personal item to nursing staff, the nursing staff are to attempt to locate the missing personal item (s) in both resident rooms and laundry and then complete the missing personal items form after the attempt to locate the missing personal item is unsuccessful. The DOC indicated the form should then be forwarded to laundry for further follow up as per the home's policy.

The DOC indicated nursing or laundry are responsible for filing out the forms and the form should have been with the ESM but they and nursing already confirmed they did not

know anything about any such forms.

Issued on this 24th day of October, 2018

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

Original report signed by the inspector.