Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2014	2014_289550_0016	O-000361-14	Resident Quality Inspection

Licensee/Titulaire de permis

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street, Clarence Creek, ON, K0A-1N0

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

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street, Clarence Creek, ON, K0A-1N0

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

JOANNE HENRIE (550), ANGELE ALBERT-RITCHIE (545), LINDA HARKINS (126), LYNE DUCHESNE (117)

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): May 5, 6, 7, 8, 9, 12, 13,14 and 15, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Dietitian/Food Services Manager (FSM), the Director of Activities (DOA), the Environmental Services Manager, the Food Services Supervisor, several Registered Nurses (RN), the RAI Coordinator, several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several Activity Aides, several Dietary Aides, one Cook, several Housekeeping Aides, one Administrative Assistant, several Residents and Family Members.

During the course of the inspection, the inspector(s) reviewed Residents Health records, the minutes of the Residents' Council, several policies: "Contrôle et entreposage des stupéfiants (Index #3.3 dated November 2006), "Vérification de la température des réfrigérateurs et congélateurs" (SD-NUT 2524, revised January 2013) and "Résident sous contentions et/ou utilisation d'appareils et dispositifs d'assistance personnel (ADAP)(protocole 6000, révisé juillet 2013), Material Safety Data Binder. Observed care and services provided to residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 17. (1) (a) (g) in that every licensee of a long-term care home did not ensure that the home is equipped with a resident-staff communication and response system that:
-can be easily seen, accessed and used by residents, staff and visitors at all times, and,
-in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

In this report the resident-staff communication and response system is commonly referred to as the call bell system.

During an interview on May 13, 2014 the Environmental Supervisor told Inspector #550 the call bells are verified on a monthly basis during the home's security inspection. Their process does not include a verification to make sure the call bells are accessible to the residents, visitors and the employees.

Room 101-B: the call bell console in the room is not equipped with a button or a cord. To be activated, a person has to push to the side the small metal piece that is attached to the console. Observation done by Inspector # 545 on May 6th, 2014.

Room #107: The call bell console in the room is not equipped with a button or a cord.

To be activated, a person has to push to the side the small metal piece that is attached to the console. Observation done by Inspector #545 on May 6th, 2014.

The Environmental Supervisor told Inspector #545, many of the resident rooms in the dementia unit have no cords or buttons attached to the call bell console because he is no longer able to get parts to repair the broken cords since the call bell system is very old. The home has decided that since the cords can be a strangulation hazard to many of the residents in the dementia unit and that many of the residents are unable to activate the call bell system on their own, they would remove the cords to those residents and most of had not been replaced with any other device.

Room #124: the call bell console is located over the resident's bed. The cord adapter is plugged into the console but there is no cord or button attached to it in order to activate the call bell. To be activated, the adapter tip has to be unplugged from the console. Inspector #550 was unable to activate the call bell in this resident's room. Observation was done by Inspector #550 on May 7th and 13th, 2014.

Shower/Tub Room on 1st floor in the dementia unit: the call bell on the left side of tub cannot be activated because the metal piece is missing. Observation done by Inspector # 545 on May 7th, 2014.

Resident adapted washroom on the 1st floor in hallway: the call bell console is located on the wall approximately 3 feet on the right hand side of the toilet. It does not have a pull cord and it cannot be reached while sitting on the toilet. A call for assistance can be made only by sliding the metal piece that is attached to the console on the wall Observation done on May 7th and 13th by Inspector #550.

Tub and shower room on the second floor wing C:
On May 05, 2014 - 15:39 - During an interview, staff #S1021 and #S1022 told Inspector # 117 they did not know if there was a call bell in the tub and shower room as they had not seen any. They said the day staff usually give baths and they are always supposed to be 2 to give the baths. The call bell was later found on the wall beside a shelving unit. The shelving unit is located between the wall and the tub and is full of linen. The call bell was not visible and accessible because the linen was in the way.

During a resident observation on May 7th, 2014, Inspector #550 observed that Resident #115's call bell cord was attached to the over bed light cord. Due to the

placement of the bed, when Resident #115 is sitting in his/her wheelchair as he/she was at the time of observation, he/she cannot access the call bell. He/she has to use his/her four legged cane and walk into the bathroom to ring the call bell. His/her wheelchair is too wide for the bathroom door frame.

During many observations during Stage 1 of inspection, all Inspectors noticed that call bells cannot be heard from the end of the hallways when activated. Speakers for the nursing call bell system are located at the nursing stations which are located at the entrance of each hallway. The secured unit has doors at the entrance of the unit which are kept closed at all times and the secured unit is facing the nursing station. Call bells from the secured unit cannot be heard when standing in the hallway or when in a resident's room starting from rooms 104 and 115 to the end of the hallway. Call bells cannot be heard from the inside of the tub and shower room on this unit.

The Administrator indicated to Inspector #550 that additional speakers were going to be installed to address this issue. [s. 17. (1)]

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 he home is equipped with a resident-staff communication and response system that:
-can be easily seen, accessed and used by residents, staff and visitors at all times, and,
-in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 37 (1) (a) in that the home did not ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids,(a) labeled within 48 hours of admission and of acquiring, in the case of new items.

During the course of the Resident Quality Inspection, Inspectors #545, #550, #117 and #126 observed unlabeled personal care items in residents' rooms, bathrooms and shared bathrooms throughout the home.
•Shower/tub room on the first floor: one large nail clipper, Arrid deodorant, Tom's natural deodorant
•Shower/tub room on the dementia unit (1st floor): Adidas After shave, one bar of soap in a plastic container

On May 12, 2014, during an observation of 22 wheelchairs in the 2nd floor dining room, Inspector #545 and RN S#1010 observed 7 out of 22 Residents sitting in wheelchairs that had not been labeled with residents' names. RN S#1010 indicated that wheelchairs should have been properly labeled to identify to Residents' personal equipment.

Personal items in the following shared bathrooms were not identified:
•Room 141: deodorant stick, shaving cream, nail clipper, toothpaste, denture cup
•Room 212: one toothbrush
•Room 108-B: one hairbrush
•Room 126-A: three toothbrushes, one denture cup
•Room 135-A: one denture cup, toothpaste, one toothbrush [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all resident's personal items such as dentures, glasses and hearing aids be labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's

response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.110 (7) 3, 4, 5, 6, 7, 8 in that the home did not ensure that a physical device used to restrain Resident# 118 under Section 31 of the Act was documented and without limiting the generality of this requirement did not ensure that the following were documented:
3. the person who made the order,what device was ordered and any instructions relating to the order
4. consent
5. the person who applied the device and the time of application
6. all assessments, re-assessment and monitoring, including the resident's response
7. every release of the device and all repositioning
8. the removal of the device

On May 7 and 12, 2014 Resident #118 was observed by Inspector #545 sitting in a reclining wheelchair with a front closure seat belt applied. When asked if Resident #118 could release the front closure seat belt, Resident #118 looked at the seat belt but was unable to release it.

On May 12, 2014 during interviews with PSW #S1013, PSW #S1008, RPN #S1012, RN #S1009, they indicated that a front closure seat belt was applied daily when Resident #118 was up in his/her reclining wheelchair and they all indicated that Resident #118 was unable to remove the front closure seat belt used to restrain him/her in the reclining wheelchair.

On May 13, 2014, the DOC indicated that in January or February 2013, the home provided Resident #118 with a reclining wheelchair with a built-in front closure seat belt. The DOC indicated that the reclining wheelchair came from the home's loan cupboard.

During an interview with RN #S1010, he/she indicated that an order for a front closure seat belt for Resident #118 was never requested; therefore there was no documentation found in Resident #118's health record. On May 12, 2014, during an interview with RN #S1010, he/she indicated that a consent for the daily use of the front closure seat belt to restrain Resident #118 was never requested; therefore there was no documentation found in Resident #118's health record.

On May 12, 2014 during interviews with PSW #S1008 and PSW #1013 they indicated that they applied the front closure seat belt to Resident #118 each time they transferred him/her to his/her reclining wheelchair but did not document they had applied the device and the time of its application.

During an interview with RPN #S1012 and RN #S1009 they indicated that they did not document the assessment, reassessment and monitoring of Resident #118, including the resident's response because a Restraint Monitoring Sheet for Resident #118 had never been started.

During discussions with PSW #S1008, PSW #S1013, RPN #S1012 and RN #S1009 they indicated that every release of the front closure seat belt and repositioning of Resident #118 was not documented.

During discussions with PSW #S1008, PSW #S1013, RPN #S1012 and RN #S1009 they indicated that the removal of the device, including time of removal of the front closure seat belt was not documented. [s. 110. (7) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents wearing a physical device used to restrain residents include the following documentation:
-the person who made the order,what device was ordered and any instructions relating to the order
-consent
-the person who applied the device and the time of application
-all assessments, re-assessment and monitoring, including the resident's response
-every release of the device and all repositioning
-the removal of the device, to be implemented voluntarily.

WN #4: 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) in that the home did not ensure that drugs were stored in an area or a medication cart that was secured and locked.

During the course of this Resident Quality Inspector, inspectors #550, #117 and #545

observed prescribed medications kept in residents rooms and bathrooms, unauthorized by a physician or registered nurse in the extended class or other prescriber. The specific observations were made on the following days by several inspectors:
Inspector #117 observed on May 7 and 8, 2014:
-Resident #090, on his/her walker: prescribed Ventolin and Advair inhalers with aerochamber, one jar of prescribed Clortrimaderm 1 % mixed 50/50 with Hyderm 1%
-Resident #155, on his/her bedside table: prescribed Spiriva 18 ug and Advair 250/50 inhalers
-Resident #106, on his/her bedside table: one jar of prescribed Menthol 1/4 % in hyderm 1% cream
-Resident #153, in cupboard above the sink: two jars of prescribed Hyderm 1% cream, one jar of clotrimaderm 1 % cream
-Resident #088, in his/her dresser drawer: prescribed ventolin and atrovent inhalers with aerochamber
-Resident #121, on his/her bedside table: one jar of prescribed hyderm 1% cream

Inspector #550 observed on May 8, 2014:
-Resident #145, in cupboard above the sink: one jar of prescribed HC1% in clotrimaderm 1% cream
-Resident #086, in cupboard above the sink: one jar of vitarub
-Resident #092, one bottle of prescribed ectosone scalp lotion in his/her cupboard above the sink and a second bottle in his/her closet , and one tube of rub A535 in cupboard above the sink
-Resident #131, in cupboard above the sink: one jar of prescribed clotrimaderm 1% cream

Inspector #545 observed on May 8, 2014:
-Resident #164, on bedside table: one jar of prescribed clotrimaderm cream 1% and one jar of prescribed Hydrocortisone Acetate Cream 1% mixed with 50/50 clotrimaderm

In discussions on May 14, 2014 with PSW #S1023, #S1024 and #1007 they indicated that prescribed creams were left at bedside for them to apply during daily resident care.

During an observation of the medication pass on May 13, 2014, Inspector #545 observed Resident #090 sitting in front of the nursing station on the second floor, with

a clear plastic bag containing Novo-Salbutamol100mcg inhaler with an aerochamber,waiting for RPN #S1012 to administer.

During an interview with the DOC on May 14, 2014 she indicated that two years ago the home directed registered staff to store all prescribed ventolin and other inhalers with aerochambers in individual plastic bags for each resident and to leave the bag at resident bedside. She also indicated that prescribed creams were left in resident's room for PSW's use and that it was common daily practice for the past three years. The DOC indicated that physician orders were not received for any of these medications to be left in the residents' rooms. [s. 129. (1) (a)]

2. The licensee has failed to comply with O.Reg 79/10 s. 129 (1) (b) in that home did not ensure that all controlled substances such as benzodiazepines were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On May 14, 2014 the DOC provided the home's policy on storage of controlled substances, titled: "Contrôle et entreposage des stupéfiants", Index N° 3.3, dated November 2006. On page 1 of the policy it is indicated that all narcotics and controlled susbtances must be controlled, stored and administered securely. On page 1 and 2, bullet 2 of the policy under the section "Procédure", it is indicated that when the home has received the narcotics and the controlled substances, they will be stored in the double-locked narcotic bin.

On May 14, 2014 during an observation of the Medication Cart on the second floor, the following benzodiazepines were found in the single-locked individual bins for five residents:
1)Resident #005: Lorazepam 1mg PO, QHS
2)Resident #006: Lorazepam 0.5mg PO, QHS
3)Resident #007: Oxazepam 10mg PO, QHS
4)Resident #008: Lorazepam 0.5mg PO, QHS
5)Resident #143: Lorazepam 0.5mg PO, QHS

During an observation of the Emergency Medication Storage in the locked Medication Room on the second floor on May 14, 2014, Inspector #545 found the following medication in the fridge, unlocked: one vial of 1ml of Lorazepam 4mg/ml injectable.

During interviews with RPN #S1012 and RN #S1020 they indicated they were not

aware that benzodiazepines were considered controlled substances and that they needed to be double-locked.

In discussion with the DOC on May 14, 2014 she indicated that the home and Medical Pharmacies were aware that benzodiazepines were controlled substances and needed to be double-locked with the narcotics but due to workload issues had decided not to implement this policy.

As such, the home did not ensure that all controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (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 all drugs are stored in an area or medication cart that is secured and locked and that all controlled substances such as benzodiazepines 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s.130. 2 in that the licensee did not ensure that the medication room where drugs are stored was restricted to only the persons, who may dispense, prescribe or administer drugs in the home.

On May 14, 2014, Inspector # 126 and #545 were in the medication room on the second floor. At that time, registered staff #S1012 and staff #S1020 were having a discussion in the room beside the medication room. A Personal Support Worker (PSW) asked staff #S1012 if she could get a bottle of peri care soap from the medication room. Staff #S1012 agreed and the PSW came into the medication room alone to get the product, without the registered staff observing.

During a discussion with the RPN he/she stated that PSWs will ask for permission to get product and if the Registered Nursing staff is around the PSW will go to get the product.

During a discussion with Maintenance Manager about the medication room he stated that he was aware of the digital number to unlock and that only nurses have the code to access this door. He was able to open the medication room with the code.

During an interview between Inspector #545 and the DOC on May 14, 2014 the DOC indicated that the administrative assistant had access to the narcotics that are stored for destruction, in the locked fire safe that is stored in the home's locked vault. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the medication room where drugs are stored was restricted to only the persons who may dispense, prescribe or administer drugs in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 3 (1) 1. in that the residents right to be treated with courtesy and respect and in a way that fully recognizes the residents individuality and respects the residents dignity was not respected when residents were not provided with knife cutlery to facilitate eating their meals.

On May 5, 6 and 7, 2014, during Stage 1 of the Resident Quality Inspection, Inspector #117 observed that during the lunch time meal service in the 2nd floor dining room, residents had only forks and spoons as utensils with which to eat their meal. No knives were noted to be at residents place settings. Nursing staff were observed to cut residents food, be they able or unable to cut their food, at the dining servery prior to serving the residents their meal.

Staff #S1005, #S1006, #S1007 and #S1026 told Inspector #S1017 on May 6th that knives have not been provided to residents on the 2nd floor dining room for over 4 years due to past safety concerns with some residents with responsive behaviours. Since then, the home has not offered any knives to residents in the 2nd floor dining room. A review of the two dining rooms on the 1st floor, by Inspectors #550 and #545 showed that residents who were able to utilize utensils and able to eat independently did have forks, spoons and knives at their place settings.

The 2nd floor dining room serves 35 residents, of which 17 are able to eat independently with no staff assistance. On May 7, 2014, 11/18 residents who are able to eat independently stated to Inspector #117 that they would like to have knives to be able to eat their food as independently as possible. Resident #153 stated that up until a few months ago, he/she and his/her spouse, who is also a resident, were eating in one of the home's 1st floor dining rooms, where they had forks, spoons and knives with which to eat. Resident #153 stated that when he/she and his/her spouse started eating in the 2nd floor dining room they were not provided any knives. When he/she asked staff for knives, he/she was told that no knives were provided to residents in the

second floor dining room, even though he/she and his/her spouse are able to eat independently. The spouse of Resident #003 visits daily and assists his/her spouse with his/her lunch time meal. He/she stated that staff have never provided him/her or Resident #003 with a knife. He/she stated that he/she has to regulary ask for a knife to assist with his/her spouse's meal.

On May 8, 2014, Inspector #550 spoke with the home's Director of Care and Administrator regarding residents not being provided knives to assist with their meals in the second floor dining room. The DOC stated to the Inspector #550 that several years ago there was an issue with some residents' responsive behaviours in the second floor dining room related to cutlery. However, she was not aware that knives were not being provided to residents who could independently and safely use knives to eat their meals. The DOC and Administrator addressed the issue and residents who requested and could use knives to eat their meals were provided with knives. [s. 3. (1) 1.]

WN #7: 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) 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 to be complied with, in that the home failed to ensure compliance with the following policies:
•« Vérification de la température des réfrigérateurs et congélateurs », SD-NUT 2524, revised January 2013

In accordance with O.Reg 79/10 s.30 and s.11 of the Long Term Care Act, that the home is required to have a dietary services program and there must be a written description of that program including relevant policies and procedures.

The home's policy « Vérification de la température des réfrigérateurs et congélateurs », indicated that temperatures of the refrigerators in the kitchenettes must be taken daily and documented on the assigned tracking sheet and when the temperature reading of the refrigerator is above 4°C (39°F), staff are required to notify the Food Services Supervisor.

During an interview with the Food Services Manager (FSM) on May 8, 2014 she indicated that to prevent contamination of food in the fridge, staff take the temperature of the refrigerators in all three Dining Rooms of the home and the readings are documented on a tracking sheet titled: "Température des réfrigérateurs". The FSM provided refrigerator temperature readings for the month of May 2014.

In reviewing the refrigerator temperature from May 1 to May 8, 2014 for the refrigerator in the Dining Room of the Dementia Unit, temperatures above 4°C were documented for the following dates and times:
•May 1 at 18:30: 5°C
•May 2 at 06:00: 5°C; at 18:30: 6°C
•May 3 at 06:00: 5°C; at 18:30: 6°C
•May 4 at 18:30: 5°C
•May 5 at 06:00: 5°C
•May 6 at 06:00: 4.5°C
•May 7 at 06:00: 5°C; at 18:30: 6°C

On May 9, 2014, during an observation of the refrigerator in the Dining Room of the Dementia Unit, the following perishable items were observed: 14 individual yoghurt, 6 carton of milk (2L), a large container of butter and a large plastic container of prepared sandwiches cut in quarters (egg salad and meat).

During an interview with the Food Services Manager and the Food Services Supervisor on May 9, 2014 they indicated that they were not aware of the refrigerator temperature readings above 4° because the staff had not notified them. The Food Services Manager indicated that the thermometer in the refrigerator of the Dining Room on the Dementia Unit should have been placed at the back of the refrigerator to

provide a more accurate reading, however it was hooked on the shelf of the refrigerator door.

The FSM gave Inspector #545 the home's policy on Temperature of Refrigerators. The FSM indicated that staff did not follow the home's policy as they did not contact the FSS or FSM on May 1 to May 7, 2014 when the temperature of the refrigerator in the Dining Room of the Dementia Unit exceeded 4°C.

As such the home did not comply with their policy "Vérification de la température des réfrigérateurs et congélateurs" SD-NUT 2524 where temperatures of the refrigerator in the Dining Room kitchenette on the Dementia Unit exceeding 4°C was not reported to the FSS or FSM. [s. 8. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007,S.O.2007, c.8, s. 57. (2) in that the Licensee does not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During an interview the Administrator and the Director of Activities told Inspector #550 the licensee does not respond in writing to the Residents' Council within 10 days of receiving their advice related to concerns or recommendations.

The DOA showed Inspector #550 the last response in writing she received was on October 15 for the meeting that was held on September 11, 2013. The last meeting was held on April 2nd, 2014. The DOA told Inspector #550 that as of May 2, 2014 she still had not received any response from the licensee. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with O. Reg. 79/10, reg. 71. (1) (f) in that the licensee does not ensure that the home's menu cycle is reviewed by the Residents' Council.

During an interview, Resident #001 who is an active member and a representative of the Resident Council told Inspector #550 the home's menu cycle has never been reviewed by the Resident Council; they will only address issues that are brought to the Council by the residents after the menu is in place.

The Director of Activities told Inspector #550 that the home's menu cycle is not being reviewed by the Resident Council. She said the summer menu cycle is scheduled to be reviewed at the next Residents Council meeting. She was unable to show inspector any documentation that the fall menu cycle had been reviewed by the Resident Council.

The Food Service Supervisor told Inspector #550 although the winter menu cycle (which was their latest menu) was updated to reflect complaints brought to her personally by the Residents, it was not reviewed by the Resident Council.

The Administrator confirmed to Inspector #550 the menu cycle has never been reviewed by the Resident Council. [s. 71. (1) (f)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)

(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there

is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, 78. (2) (a) (g) (k) (m) (q) in that the package of information does not include at a minimum:
-the Resident's Bill of Rights,
-notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained,
-information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges,
-a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs, and,
-an explanation of the protections afforded by section 26.

The Director of Care indicated on the LTCH Licensee Confirmation checklist Admission Process that was given to her upon the first day of the RQI and during an interview with Inspector #550 that the package of information given to very resident and the substitute decision maker at the time the resident is admitted does not contain the following information:
-the Resident's Bill of Rights,
-notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained,
-information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges,
-a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs, and,
-an explanation of the protections afforded by section 26. [s. 78. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, 79. 3.(g) (k) in that the licensee does not ensure that the required information is posted in the home, in a conspicuous and accessible location in a manner that complies with the requirements, if any, established in the regulations. The required information to be posted is:
-notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained and,
-copies of the inspection reports from the past two years for the long-term care home.

During the initial tour of the Home on May 2nd, 2014 Inspector #117 observed that a copy of the latest inspection report for an inspection conducted on November 26, 27 and 28, 2013 was posted in the home's entrance. Other inspection reports from inspections that were conducted in the past two years were not posted. The long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained were also not posted.

During another observation on May 7th, 2014 Inspector #550 observed the inspection report for the inspection that was held on November 26, 27 and 28, 2013 was no longer posted and was replaced by inspection reports for inspections that were held on August 9, 2013 and July 4, 2013.

During a discussion, the Director of Care indicated to Inspector #550:
-notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained and,
-copies of the inspection reports from the past two years for the long-term care home are not posted in the home. [s. 79. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 91 in that the licensee did not ensure that all hazardous substances are kept inaccessible to residents at all times.

On May 14, 2014 Inspector #126 observed inside the unlocked tub and shower room on the second floor in hallway (rooms 220-237), a cupboard that was also unlock and had 2 bottles of disinfectant "cleanser IV" which is a product that is poison and corrosive.

Discussion held with Maintenance Manager who indicated that these bottles should be kept in a locked area at all times. The Manager removed the 2 bottles and locked them up in the housekeeping cupboard. [s. 91.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 114. (2) in that the home did not ensure that written policies and protocols are developed for the medication management system to ensure the accurate destruction and disposal of all drugs used in the home.

During an interview with the DOC on May 14, 2014 she indicated that while the home has a process in place on how to destroy and dispose of all drugs in the home, the home has never developed a written policies and protocols to ensure the accurate destruction and disposal of all drugs used in the home. [s. 114. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 229. (10) 1 in that the licensee did not ensure that resident admitted to the home are screened for tuberculosis within 14 days of admission.

The following 3 residents were not screened for tuberculosis within 14 days:
Resident #009 was admitted to the home on a specific day in March, 2014 and was not screened for tuberculosis as of today May 9, 2014.
Resident #010 was admitted to the home on a specific day in November, 2013 and was screened for tuberculosis on a specific day in December, 2013, more than 14 days later.
Resident #011 was admitted to the home on a specific day in March, 2014 and was not screened for tuberculosis as of today May 9, 2014. [s. 229. (10) 1.]

Issued on this 23rd day of May, 2014

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