**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**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 10, 2014 | 2014_259520_0010 | L-000238-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

COLUMBIA FOREST
650 MOUNTAIN MAPLE AVENUE, WATERLOO, ON, N2V-2P7

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

SALLY ASHBY (520), SHARON PERRY (155), TAMMY SZYMANOWSKI (165)

## 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): March 5, 6, 7, 10, 11, 12, 13, 14, 17, 2014

Critical Incident L-000140-14 and Complaint L-000242-14 were also completed during the RQI process.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Regional Manager Clinical Services, Director of Care (DOC), 2 Assistant Director of Care (ADOC), Environmental Services Manager, Compass District Manager, 4 Registered Nurses (RN), 2 Registered Practical Nurses (RPN), Food Services Manager, Education Manager, Program Manager, Cook, 2 Dietary Aides, 13 Personal Support Workers (PSW), 2 Housekeepers, Laundry Aide, 40 plus Residents, 3 Family Members and Receptionist/Scheduler.

During the course of the inspection, the inspector(s) reviewed clinical records, toured the home, observed staff/resident interactions, observed care provided to residents, reviewed policies and procedures, observed medication administration and dining routines and reviewed minutes of committee meetings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**
**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to the residents.

During the month of March 2014 at approximately 1515 hours, resident #300 was observed sleeping on a therapeutic surface with two half side rails in the raised position and a pillow placed against each half rail. Upon observation there was approximately a five inch gap from the head of bed and there were no bolsters in place. Interviews confirmed that there was no assessment of entrapment zones completed for resident #300 who was observed using side rails.

During the month of March 2014 at approximately 1000 hours, resident #306 was observed laying on their therapeutic surface with two half side rails in the raised position with side rail protectors. Upon observation there were no bolsters in place. Interviews confirmed that there was no assessment of entrapment zones completed for resident #306 who was observed using side rails.

Interviews with the Environmental Services Manager and Executive Director revealed that where bed rails were used for all residents, including for residents using therapeutic surfaces, their bed systems were not evaluated. [s. 15. (1) (a)]

***Additional Required Actions:***

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

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

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

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

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

**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #589 was observed during the month of March 2014 sleeping in bed with one bed rail in the up position. The resident and a PSW reported that the resident was capable of independently getting out of bed and uses one bed rail when sleeping however; the resident's plan of care related to transfers indicated the resident did not use bed rails.

Care plan of February 2014, gives direction to do Head to Toe Assessments every 24hours and also to do quarterly and PRN.
Interview with a Registered Staff Member in a home care area. Inspector asked the Registered Staff Member to check resident's care plan and clarify when the Head to Toe Assessments should be done. The Registered Staff Member verified that there were two conflicting times to do Head to Toe Assessments in the care plan for resident #489. Resident #489's care plan dated February 2014 states to do a Head to Toe Assessment every 24 hours, quarterly and when necessary (PRN). During an interview, the Registered Staff Member stated the Head to Toe Assessment should be done every 24 hours and that the other one was an error and needed to be removed from the care plan. [s. 6. (1) (c)]

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

Eight identified residents had individualized nourishments scheduled for the morning nourishment pass. However, the morning nourishments were not provided on a date during the month of March 2014, in a home care area. The Dietary Aide confirmed that morning nourishments were not delivered. [s. 6. (7)]

***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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that this care is provided per the plan of care, to be implemented voluntarily.***

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**WN #3: 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).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that any policy put in place is complied with.

Review of Medication Administration Policy (LTC-F-20) states that liquid medication in excess of 10 mls is measured into a plastic cup according to the MAR (liquid medications of less than 10 mls are measured by the dose syringe and contents are released into plastic cups).
During the month of March, during noon medication pass in a home care area the Registered Staff Member was observed pouring a medication into a plastic drinking cup and paper dixie cups without measuring the amount with a plastic medication cup. The Registered Staff Member confirmed that the medication should have been measured but stated a knowledge of the exact amounts. [s. 8. (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 any policy put in place is complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The following was observed during the inspection:
The vents in the main kitchen were dirty. The Food Service Manager confirmed that the dirty vents had been previously identified by audits however had not been cleaned when observed on a date during the month of March 2014.

Home Area
Shower Room: shower floor had a build up of dirt in the grout on the floor
Spa Room: shower curtain noted to be soiled and towels/rags noted on floor behind the tub

Home Area
Spa Room: shower floor had a build up of dirt in the grout on the floor

Home Area

During the month of March 2014, at 1145 hours during a walk-through with the Environmental Services Manager it was noted that the carpet in a resident's room was soiled with a brown like substance about 2 inches in diameter. This room was noted to be scheduled for cleaning multiple times a day. At 1405 hours the soiled area remained on the carpet.
Spa Room: privacy curtain between tub and toileting area noted to be soiled
Spa Room: shower floor had a build up of dirt in the grout on the floor

Home Area
Spa Room: shower floor had a build up of dirt in the grout on the floor
Spa Room: shower curtain noted to be soiled

Home Area
Spa Room: shower curtain was noted to be soiled
Shower Room: shower floor had a build up of dirt in the grout on the floor and caulking at base of shower noted to be cracked and black in colour

Home Area
Shower Room: shower floor had a build up of dirt in the grout of the floor [s. 15. (2) (a)]

2. The licensee of the long term care home failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during the inspection:
Home Area
Spa Room: wall damage noted by the shower area and flooring by the tub noted to be worn
-Threshold strip from carpet to laminate flooring missing
-Wood door to activity room/lounge noted to be chipped on the bottom half of the door
-3 Resident rooms noted to have wall damage

Home Area
-Threshold strip from carpet to laminate flooring missing
-Wood door to dining room and lounge/activity room chipped on the bottom half of the door

Home Area

Spa Room: floor around tub noted to be worn and wall damage noted by shower area
Shower Room: noted to have wall damage
-Wood door to activity room noted to be chipped on the bottom half of the door
-Resident room noted to have wall damage in the room by the bathroom door
-Threshold strip from carpet to laminate flooring missing

Home Area
Spa Room: noted to have crack in the flooring by the shower
-Wood door to dining room and lounge by nursing desk noted to be chipped on bottom half of the door
-Threshold strip from carpet to laminate flooring missing

Home Area
Spa Room: noted to have wall damage
-Threshold strip from carpet to laminate flooring missing

Home Area
-Wood door to dining room and lounge by nursing desk noted to be chipped on bottom half of the door
-Threshold strip from carpet to laminate flooring missing

During the month of March 2014, the Environmental Services Manager verified the maintenance concerns and indicated that all staff are to report maintenance concerns so that they can be addressed. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #5: 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).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to 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.

During the month of March 2014, when doing observation of resident #449, resident was asked to ring the call bell. Resident was unable to push the green button style call bell hard enough to make it activate. During the month of March 2014, at 1340 hours inspector asked resident #449 to try to push the call bell enough to activate it. Resident was not able to activate the call bell. This was verified by an Assistant Director of Care.

During the month of March 2014, when doing observations of a home care area Spa Room it was noted that the call bell cords located near the door, in shower area, and tub broke when pulled and did not activate the call bell. A PSW verified that the call bells broke without activating the call bell response system.

During the month of March 2014, at 1100 hours a resident in their room was unable to activate the call bell stating it sticks and that they rely on the call bell in the bathroom. In another resident room the call bell broke in the resident's bathroom this was verified by the Environmental Services Manager.

During the month of March 2014, at 1040 hours when doing observations of a home care area Spa Room it was noted that the call bell cords located near the sink, tub, toilet and in shower area broke when pulled and did not activate the call bell. A PSW verified that all of the call bell cords broke without activating the call bell response system.

During the month of March 2014, it was noted that the following call bell cords would detach from the call bell making the system not accessible to residents and staff at all times:
Home Area
Shower Room: call bell cord in shower

Home Area
Spa Room: two call bell cords by tub and call bell cord in shower
During the month of March 2014, Environmental Services Manager confirmed that the call bell cords detached when pulled making the system not accessible to residents and staff at all times. [s. 17. (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 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, to be implemented voluntarily.*

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

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

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that every alleged, suspected or witnessed abuse of a resident by anyone that the licensee knows of or that was reported was immediately investigated.

During the month of March 2014, during the supper meal, it was reported to a Registered Staff Member by resident #589 that they had been treated roughly while being bathed. The Registered Staff Member immediately reported the alleged abuse to the Assistant Director of Care. During an interview, the Assistant Director of Care reported that they were informed by the PSW working that the resident was not bathed on a date in March 2014, and the resident had been confused. The Assistant Director of Care confirmed that they did not treat the allegation as alleged or suspected abuse because the resident was reported as confused. The Assistant Director of Care verified an immediate investigation was not initiated and no investigation notes were completed regarding the allegation. The Executive Director and the Director of Care did not complete an investigation and confirmed that they were unaware of the alleged abuse. A review of the resident's clinical health record revealed that the resident was bathed by the PSW working 1400-2200 hours on a date in March 2014. The home's Resident Non-Abuse Policy (LP-C-20) indicated that an immediate dignified and respectful investigation of the reported alleged, suspected or witnessed abuse would be initiated by the Executive Director or designate. [s. 23. (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 that every alleged, suspected or witnessed abuse of a resident by anyone that the licensee knows of or that is reported is immediately investigated, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

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

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that the restraining of the resident is included in the resident's plan of care.

During the month of March 2014, resident's #301, #302, #507 and #554 had restraints applied.
Registered staff confirmed that resident #507 and #300 were physical restraints. The plans of care for both residents did not include the use of physical restraints.

During the month of March 2014, resident #554 was unable to undo the physical restraint when asked by the inspector. The resident's plan of care did not include the use of the physical device.

During the month of March 2014, resident #302 was observed with a restraint. During the month of March 2014, at approximately 1450 hours, the resident was unable to undo the physical restraint when asked by the inspector. The resident's plan of care did not include the use of the physical device.

During the month of March 2014, resident #301 had a restraint. Review of the resident's clinical health record revealed the physical device was discontinued by the physician during in the fall of 2013. [s. 31. (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 the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

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

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #574 reported that staff did not always provide a bath twice a week as scheduled. A review of the point of care records indicated that the resident was not bathed four dates in February 2014, as scheduled. Assistant Director of Care verified that the resident was not bathed twice a week during this time period and that there was no evidence that a bath was offered by staff and refused by the resident.

Resident #563 was not bathed, at a minimum of twice a week. Review of resident #563 bath documentation indicated that for the period beginning February 2014 to mid March 2014, the resident did not receive any bath/shower on one date in February and two dates in March 2014 (3/7 times). The Director of Care confirmed that the expectation of the home is that if a bath or shower is given then it is to be documented. There was no evidence that a bath was offered by staff and refused by the resident. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.***

**WN #9: 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 :**

1. The licensee of the long term care home failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

During the month of March 2014 the lunch meal in a Home Area, it was noted that the beef vegetable soup served was made with ground beef. When poured in a glass the soup was separated. A review of the standardized recipe indicated that 1/4 pieces of stew meat was to be used in the soup. The Food Service Manager confirmed that stew meat was available however, not used for the soup.

During the month of March 2014, the regular and minced textured sausage and the regular, minced and puree meatballs for the dinner meal were already completed and in hot holding at 1400 hours when the inspector entered the main kitchen. The cook was completing the pureed sausage which was placed in hot holding at 1414 hours. Prep time lines directed staff to cook regular entrees at 1400 hours, cook all textured menu items at 1545 hours and blend all textured items at 1600 hours. The cook stated that the sausage only required 10 minutes for cooking time and could have been started later. The food items were held in hot holding for at least three hours prior to meal service and the Food Service Manager reported that cooks were to follow the prep time lines. At approximately 1700 hours during the dinner meal, the pureed meatballs had a hard layered crust around the edges and the minced meatballs were dry and contained dark hard pieces.

During the month of March 2014, in a Home Area they ran short of mashed potatoes. The Dietary Aide called other home areas however, there was none available. [s. 72. (3) (a)]

*Additional Required Actions:*

*VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.*

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

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

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that the home had a dining and snack service that included, at a minimum, food and fluids being served at a temperature that was both safe and palatable to the residents.

On a date during the month of March 2014, during the breakfast meal, temperatures of puree cottage cheese in three home areas ranged from 8.6 to 20.2 degrees celsius. The menu items were not kept on ice baths to assist in maintaining temperatures throughout meal service.

On a date during the month of March 2014, during the lunch meal in a Home Area, temperature of the puree potato salad was 7.6 degrees celsius.

On a date during the month of March 2014, during the dinner meal in a Home Area, temperature of the carrots was 51.8 degrees.

Several residents interviewed throughout the inspection voiced concerns related to temperatures of food items throughout meal service. Several resident interviews identified eggs as a concern. During the month of March 2014, at approximately 0915 hours the temperature of the regular eggs were 51.6 degrees celsius and 55.3 degrees celsius for the pureed eggs. Once identified the Dietary Aide heated the products for the remaining residents. [s. 73. (1) 6.]

2. The licensee of the long term care home failed to ensure that the home had a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On a date during the month of March 2014, during the lunch meal service in a Home Area resident #302 was observed leaning to the left side with head down. Staff did not attempt to position the resident and food was being lost on the resident's clothing protector.

On a date during the month of March 2014, during the lunch meal service in a Home Area resident #301 was observed leaning to the right. Staff did not attempt to position the resident when assisting the resident to eat. [s. 73. (1) 10.]

*Additional Required Actions:*

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, food and fluids served at a temperature that is both safe and palatable to the residents and there are proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #11: 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).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that procedures are developed and implemented so there is a process to report and locate residents' lost clothing and personal items.

During resident interviews, resident #489, #574, #589 all reported that they were missing clothing. 2/3 indicated that because of this they themselves or family now do their laundry.

The Environmental Services Manager shared the home's process for reporting residents' lost clothing. This process included a "Missing Clothing Checklist" that is to be completed by the employee receiving the complaint.

Interviews with 6 staff confirmed that they had never seen the "Missing Clothing Checklist" nor were they aware that it was the process in the home for reporting lost clothing. [s. 89. (1) (a) (iv)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented so there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation**

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

**s. 115. (3) The quarterly evaluation of the medication management system must include at least,**
**(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).**
**(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).**
**(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).**

**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that the quarterly evaluation of the medication management system included reviewing reports of any medication incidents and adverse drug reactions .

Review of the Medical Advisory Committee meeting minutes of November 4, 2013, and February 3, 2014, did not include a review of medication incidents. The Director of Care confirmed that medication incidents were not reviewed quarterly during the Medical Advisory Committee meetings. [s. 115. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the quarterly evaluation of the medication management system includes reviewing reports of any medication incidents and adverse drug reactions, to be implemented voluntarily.***

**WN #13: 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).**

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**Findings/Faits saillants :**

1. The licensee of the long term care home failed to ensure that controlled substances are stored in a separate locked area within the locked medication cart.

During the month of March 2014, at 1226 hours in a Home Area, it was noted that the separate locked area on the medication cart that contained controlled substances was not locked. The Registered Staff Member confirmed that it was not locked. [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 controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.***

**WN #14: 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 of the long term care home failed to ensure that all areas where drugs are stored are kept locked at all time when not in use.

During the month of March 2014, at 1206 hours the medication cart in a Home Area was left unlocked an unattended. The Registered Staff Member was in the dining room administering medications to the residents over by the window and medication cart was not locked. A PSW confirmed that medication cart was unlocked. The Registered Staff Member confirmed that the expectation is that if the medication cart is out of sight it is to be locked.

During the month of March 2014, at 1155 hours the medication cart outside a Home Area Dining Room was left unlocked and unattended. In addition the E-MAR was open and a resident's medication profile was visible on the screen. The Registered Staff Member confirmed the medication cart was unlocked and the E-MAR was open and visible. The Registered Staff Member further confirmed the expectation of the home was to have the medication cart locked and the E-MAR closed when unattended. [s. 130. 1.]