**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**
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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 23, 2014 | 2014_179103_0014 | O-000384-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

KEAY NURSING HOMES INC
10-112 Red Pine Road, P.O. Box 21, GRAND BEND, ON, N0M-1Z0

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

E. J. MCQUIGGE LODGE
38 Black Diamond Road, P.O. Box 68, Cannifton, ON, K0K-1K0

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

DARLENE MURPHY (103), AMBER MOASE (541), JESSICA PATTISON (197), SUSAN DONNAN (531)

**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 12-16, 20-21, 2014**

**During this inspection, the following two complaint logs were also inspected: O-000700-13 and O-000294-14.**

**During the course of the inspection, the inspector(s) spoke with Residents, Resident Council Representative, Family members, Health Care Aides (HCA), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Dietitian, Food Service Supervisor, Dietary Aides, Activity Manager, Activity staff, Physiotherapist, Physiotherapy assistants, Housekeeping Manager, Housekeeping staff, Maintenance worker, Ward clerk, RAI Coordinator, Director of Care (DOC), and the Administrator**

**During the course of the inspection, the inspector(s) conducted an initial walkthrough of the resident home areas, observed resident dining, resident activities, medication administration and resident care, inspected medication storage areas, reviewed resident health care records, and reviewed home policies.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**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**
**Sufficient Staffing**

**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 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:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, s. 3 (1) 8. whereby the resident is not afforded privacy in treatment and in caring for his or her personal care needs.

During an interview with Resident #2586, the resident reported to the inspector that staff never close the bedroom door and do not always close the privacy curtains when providing care to residents in the room.

During an interview with Resident #2632, the inspector observed two staff entering the resident room through the closed door and then proceeding to transfer a co-resident into bed without closing the privacy curtains. [s. 3. (1) 8.]

2. The licensee has failed to comply with LTCHA, 2007 s. 3 (1) 14. whereby the resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference was not respected.

Inspectors were conducting interviews with residents and family members on May 12-14, 2014. During the interviews, resident bedroom doors were closed to facilitate privacy. During the following interviews, staff were observed to walk through the closed doors and proceed into the room to complete their duties without any acknowledgment of the disruption to the resident's privacy:

Residents #2586, #2601, #2651, #2654, #2623, #2632, #2618, #2622 and #2650. (#103, #531, #197, #541) [s. 3. (1) 14.]

*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 residents have the right to communicate in confidence with any person without interference and to be afforded privacy in treatment and caring for his or her personal needs, to be implemented voluntarily.***

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

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

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

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Regs. 79/10, s. 8(1)(b) in that the home's Monthly Resident Weight Monitoring policy was not complied with.

O. Regs. 79/10, s. 68(2)(e) states that every licensee of a long-term care home shall ensure that the organized program of nutrition care and dietary services includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

The home's policy, "Monthly Resident Weight Monitoring" states:
- All investigation and actions taken related to significant weight changes must be documented in the resident's chart in the multi-disciplinary progress notes by the Clinical Dietitian.
- Within the Weighing Process, specifies that weights are all due by the 10th of each month so the Dietitian can assess the residents' needs.

Resident #2591 had identified weight changes in the months of January, February, and April 2014.
Resident #2611 had identified weight changes in the months of January and April 2014.
Resident #2646 had identified weight changes in the months of February, March and April 2014.

No investigations or actions taken in relation to the above weight changes were documented in the residents' multi-disciplinary progress notes.

The February weights for Residents #2591, #2611 and #2646 were documented as being completed on February 18, 2014.
The May weights for the same residents were documented as being completed on May 13, 2014.
Therefore, the weights for these months were not done by the 10th of the month. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Monthly Resident Weight Monitoring policy is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

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

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (a) whereby the home, furnishing and equipment are not kept clean and sanitary.

The following observations were made during the inspection:

Rooms #1,2,4,7,8,17,18, 22 and 23 were observed to have a build-up of dirt on the bedroom and bathroom floors,

Resident #2584's walker at the bedside was heavily soiled with dirt-like and food-like materials with evidence of dust on the frame,

Resident #2622's wrist protectors on the acrylic wheelchair tray were visibly soiled,

The shower room was observed to have a black coloured build-up noted on the corners of the floor at the shower edge and up the sides of the steel-like material on the walls of the shower. There was visible dust in the overhead vent, on the grab bar mounted on the wall beside the shower, and a build-up of dirt on the floor and

cobwebs were evident in the overhead ceiling lights,

Room #18 was observed to have visible dirt on the wall, clothes cupboard and window sill,

Room #2 was observed to have dust on the radiator in the bathroom and the grab bars appeared dirty,

Room #23 was observed to have water staining on the ceiling. (#103,#197,#541, #531) [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007 s. 15 (2) (c) whereby the home, furnishings and equipment are not maintained in a safe condition and in a good state of repair.

The following observations were made during the inspection:

Resident #1- right arm rest of wheelchair had a crack in the finish and was rough to touch,

Resident #2608-both wheelchair armrests were cracked and worn,

Resident #2650-both wheelchair armrests were cracked and rough to touch,

Resident #2601-right wheelchair arm rest was cracked and rough,

Resident #2613-left wheelchair arm rest had black tape on edge of arm rest which was lifting and rough to touch,

Resident #2598-wheelchair tray was fraying at edges,

The pink colored chairs in the lounge are stained and worn,

A grab bar in the shower room is noted to have rust evident on the bar and there are holes in the wall that have not been repaired,

Room #2-the toilet seat finish was observed to be worn away, the wall behind a resident bed had been repaired but not sanded or painted and there were numerous

screw holes in the wall above the bed,

Room #23- the baseboard heater had evidence of rust on the surface, there was an area of plaster repair noted above the window that was not painted, there were numerous areas of paint missing at the base of the door going into the bathroom and the floor at the toilet base was scuffed; the baseboard was observed to be detached and pulled away from the wall beside the toilet and there were broken wall tiles noted at the baseboard level in the bathroom; there were several gouges in the floor surface near the legs of the bed,

Room #8- the bathroom door and frame around the door had large areas of paint missing and there were holes evident where a previous towel rack was located,

Room #22-there was rust noted on the floor at base of toilet where the bowl meets the floor and abrasions in the paint were observed on the lower end of the wall by a resident bed,

Room #15-the wall along the right side of the window had numerous small holes that were not repaired,

Room #4-the wall outside the bathroom was missing paint and had numerous pinholes in the wall that have not been repaired; the plaster in the corner outside of the bathroom was noted to be damaged and the wall had several marks in the paint,

Room #18-a large hole was observed in the wall behind the resident bed as well as large gouges in the wall; the bathroom door and frame around the door was missing paint as well as the radiator,

Room #17-there was paint missing on the bathroom door and door frame,

Room #1-the wall behind the bed was observed to have unrepaired holes,

Room #9-there are large areas of paint peeling off the bathroom door,

Infirmary A-a split in the drywall under the window was observed. (#103, #197, #531, #541) [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 the home, furnishings and equipment are kept clean and sanitary and are in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes**

**Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

**1. A change of 5 per cent of body weight, or more, over one month.**

**2. A change of 7.5 per cent of body weight, or more, over three months.**

**3. A change of 10 per cent of body weight, or more, over 6 months.**

**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Regs. 79/10, s. 69 in that specified weight changes are not assessed using an interdisciplinary approach.

Resident #2591 is on a specified special diet, receives a nutritional supplement twice a day at nourishments and is assessed as high nutritional risk.
Resident #2591 had the following weight changes:
- a loss of 10.58 per cent body weight over 6 months in May 2014,
- a loss of 11.64 per cent body weight over 6 months in April 2014,
- a loss of 7.97 per cent body weight over 3 months and a loss of 12.30 per cent body weight over 6 months in February 2014,
- a loss of 9.26 per cent body weight over 3 months and a loss of 12.50 per cent body weight over 6 months in January 2014.

The Registered Dietitian completed a quarterly assessment on Resident #2591 on March 25, 2014.

A review of the resident's health care record, including assessments provided by the Food Service Supervisor, showed no evidence that the resident's weight losses were assessed in January, February or April 2014.

Resident #2611 is on a regular diet (small portions by request at dinner time), receives two different nutritional supplements, one three times a day at nourishments and the other two times a day at medication pass. This resident is also assessed as high nutritional risk.
Resident #2611 had the following weight changes:
- a loss of 9.12 per cent body weight over 3 months and a loss of 13.50 per cent over 6 months in May 2014,
- a loss of 7.33 per cent body weight over 1 month and a loss of 10.90 per cent body weight over 6 months in April 2014,
- a loss of 11.82 per cent body weight over 6 months in January 2014.

The Registered Dietitian completed a quarterly assessment on Resident #2611 on February 25 and May 20, 2014.
A review of the resident's health care record, including assessments provided by the Food Service Supervisor, showed no evidence that the resident's weight losses were assessed for the months of January or April 2014.

Resident #2646 is on a specified special diet, receives a nutritional supplement three times a day and is assessed as high nutritional risk.
Resident #2646 had the following weight changes:
- a loss of 13.87 per cent body weight over 6 months in May 2014,
- a loss of 11.31 per cent body weight over 6 months in April 2014,
- a loss of 10.37 weight over 6 months in March 2014,
- a loss of 10.22 per cent body weight over 3 months in February 2014,
- a loss of 8.76 per cent body weight over 3 months in January 2014.

The Registered Dietitian completed quarterly assessments for Resident #2646 on January 20 and April 21, 2014.
A review of the resident's health care record, including assessments provided by the Food Service Supervisor, showed no evidence that the resident's weight losses were assessed in February or March, 2014.

The home's Monthly Resident Weight Monitoring policy states that significant weight changes (5% change in one month, 7.5% change in 3 months and 10% change in six

months) are reviewed and prioritized by the Clinical Dietitian for follow-up. This policy also states that all investigation and actions taken related to significant weight changes must be documented in the resident's chart in the multi-disciplinary progress notes by the Clinical Dietitian.

During an interview with the Director of Care on May 21, 2014, she stated that the expectation is for the Registered Dietitian to follow-up and assess weight changes within two weeks of the identified weight change.

A phone interview was conducted with the Registered Dietitian on May 21, 2014. During this interview, she stated that May 2014 was the first month she had completed assessments related to weight changes since she started working in the home in December 2013. She confirmed that assessments related to weight changes prior to May 2014 had not been completed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

***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 specified weight changes are assessed using an interdisciplinary approach, to be implemented voluntarily.***

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**WN #5: 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. Regs. 79/10, s.129 (1)(a)(ii) whereby drugs that are stored in an area or a medication cart was not secured and locked.

On May 13th, 2014, RN S#114 was observed leaving the medication cart unlocked while administering breakfast medications to Resident's #2662, #2610 and #2603. The cart was not within sight of the nurse during these times. RN S#114 was also observed leaving the medication cart unlocked and out of the staff member's sight with resident medications poured and left unattended on the top of the medication cart.

On May 15th, 2014, the following observations were made: RPN S#104 administered a medication to Resident #2592 leaving the medication cart outside in the hall unlocked, and out of the registered staff member's sight.

The medication cart was again left unlocked and out of the staff member's sights while attending to Resident #12 in the resident's room. Resident #12's medications had been prepared and was left on top of the medication cart. Resident #2640 was in the vicinity of the medication cart at that time.

On May 15th, 2014, S#102 administered medications on or about 1700 hours to Residents #2650, #2629 and #13 in their rooms with the resident doors closed leaving the cart unlocked and out of the sight of the registered staff member.

A review of the home's policy 3-5 "The Medication Cart and Maintenance" and policy 3-6 "The Medication Pass" Setting up for the Medication Pass, states "wheel the cart to the area where the medication administration begins. Ensure that the cart is locked if out of sight of the nurse". [s. 129. (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 medication carts are locked when unattended and not within view of the registered staff, to be implemented voluntarily.***

**WN #6: 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 failed to comply with O. Regs. 79/10, s. 130(2) whereby access to the medication room where drugs are stored are not restricted to persons who may dispense, prescribe or administer drugs in the home.

On February 15th, 2014, RN S#112 locked the keys which access the medication room inside the room. This staff member was able to contact S#108 who attended the home and opened the medication room with the spare key from the main office. S#108 is not a member of the registered staff.

S#112 was interviewed and confirmed that S#108 arrived at the home on or about 0545 hours and opened the medication room door using the spare key from the main office.

The Director of Care was interviewed and confirmed that an access key to the medication room is stored on top of her desk in the main office which is shared with S#108 . The Director of Care confirmed that S#108 has access to the main office. [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 access to all medication areas are only accessible by registered staff, 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. 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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that the plan of care for a resident does not provide clear direction to staff related to positioning.

On May 12, 2014 at the lunch meal, Resident #2646 was observed receiving feeding assistance by a staff member. The resident was poorly positioned throughout the meal and required frequent readjustment by the staff member.

On May 16, 2014, Resident #2646 was again receiving feeding assistance from S#110 at the lunch meal. At this time, the staff member had a large white pillow that was used to help position the resident's body for feeding. Inspector spoke with S#120 in the dining room about the resident's positioning. The staff member stated that the resident sits up well most of the time and that his/her positioning has recently become an issue. The staff member also stated that the resident does not normally need a pillow for positioning.

The Food Service Supervisor was interviewed on May 16, 2014 and stated staff reposition the resident as required. She further stated that to her knowledge no formal assessment related to the resident's positioning at meal times had been completed.

On May 21, 2014, Resident #2646 was observed receiving feeding assistance from S#110 at the lunch meal. On this day the large white pillow was not used. A small pink pillow was observed in the resident's lap. The staff member stated that this pillow is used as staff see fit and that the staff has been trying a few different methods to help the resident's positioning at meal time. The staff member also stated that Resident #2646's positioning has been a concern for at least one month, but is unsure exactly when the issue started (#197)

On May 21, 2014, S#119 was interviewed in regards to Resident #2646's positioning needs. The staff member stated repositioning can be difficult at times and there is little the staff can do to make the resident comfortable.

Resident #2646's plan of care in effect at the time of this inspection was reviewed. Positioning for this resident is addressed under Activities of Daily Living and stated, "ensure the resident is positioned properly during meals".

The care plan fails to provide staff with clear directions related to positioning. (#103) [s. 6. (1) (c)]

**WN #8: 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. Regs. 79/10 s. 37 (a) whereby personal items were unlabelled.

During the inspection period, the shower room storage cupboard was observed to have opened and used unlabelled female brand and male brand deodorants. Room #11 had an unlabelled hair brush with hair evident in the brush left on the tray of the hand sanitizer inside the resident room. [s. 37. (1)]

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

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

**s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:**
**1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).**
**2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).**
**3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).**
**4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).**
**5. The reason for destruction. O. Reg. 79/10, s. 136 (4).**
**6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).**
**7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).**
**8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. s. 136. (4)(7) the drug destruction and disposal drug record did not provide the names of the persons who destroyed the drug.

The destruction of controlled drugs records were reviewed. On February 18th, 2013, March 7th, 2013, April 7th, 2013, June 6th, 2013, September 13th, 2013, and January 27th, 2014 the Pharmacist was the only signature on the records for the destruction.

The Director of Care was interviewed and stated she had omitted signing the records along with the Pharmacist. [s. 136. (4)]

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**WN #10: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Regs 79/10 s. 229 (4) whereby staff do not participate in the implementation of the infection prevention and control program.

Throughout the inspection period the following items were observed being stored on the back of resident toilets:

Room 2-urine collection container,
Room 7-urine collection container,
Room 19-bedpan and wash basin,
Room 23-two urinals and an incontinent product,
Room 22-a box of tissues.

Additionally, the bathrooms for Rooms 8, 10, 11, 18, and 19 were observed to have toilet plungers sitting directly on the floor next to the toilet. The plungers appeared soiled with bits of toilet tissue adhered to them.

In an interview with the Director of Care and Infection Control Lead, she advised items are not to be stored on the back of the toilet and agreed it poses a risk of cross contamination to the residents sharing the bathroom. Each shared bathroom has resident specific storage bags located on labelled hooks where urinals and bed pans should be stored. Additionally, the DOC stated it would be her expectation that the toilet plungers located in the resident bathrooms should not be resting directly on the floor of the bathroom. [s. 229. (4)]

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

**Issued on this 23rd day of May, 2014**

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
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| Darlene Murphy, Jessica Pattison, Amber Moase, Sue Donnan |