Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
Sudbury ON P3E 6A5

Telephone: 705-564-3130
Facsimile: 705-564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
Sudbury ON P3E 6A5

Téléphone: 705-564-3130
Télécopieur: 705-564-3133

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Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 21st, 2011 through April 1st, 2011.	2011_188_2609_20Mar221756 2011_158_2609_21Mar150923 2011_177_2609_21Mar161323 2011_106_2609_22Mar091225	Annual, S-001170-11

Licensee/Titulaire
New Orchard Lodge Limited [a subsidary of Extendicare (Canada) Inc.], 3000 Steeles Avenue East. Suite 700, Markham, ON, L3R 9W2, Fax: 905-470-5588

Long-Term Care Home/Foyer de soins de longue durée
Extendicare Van Daele, 39 Van Daele Street, Sault Ste Marie, ON, P6B 4V3, Fax: 705-945-0968

Name of Inspector(s)/Nom de l'inspecteur(s)
Margot Burns-Prouty (106), Melissa Chisholm (188); Anne Costeloe (177); Kelly-Jean Schienbein (158)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an annual inspection.

During the course of the inspection, the inspectors spoke with: the Acting Administrator/Director of Care, the Acting Director of Care/Assistant Director of Care, the Office Manager, the Support Services Manager, the Admissions Coordinator, the Dietary Manager, registered nursing staff, personal support workers (PSW), housekeeping staff, the Resident Programs Manager, resident program staff, Family Council President, Resident Council Present, maintenance staff, dietary staff and rehabilitation staff.

During the course of the inspection, the inspectors: Conducted a walk-through of all resident home areas and various common areas, observed the care of residents, observed meal service, interviewed residents, staff and families and reviewed the following:

- Various policies and procedures
- Staffing schedules and patterns
- Health care records of current and discharged residents

The following Inspection Protocols were used during this inspection:
Admission Process
Infection Prevention and Control
Medication
Resident Charges
Resident Council
Family Council
Quality Improvement
Dining Observation
Accommodation Services: Laundry
Accommodation Services: Maintenance
Accommodation Services: Housekeeping
Continence Care and Bowel Management
Pain
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Minimizing of Restraining
Personal Support Services
Hospitalization and Death
Prevention of Abuse, Neglect and Retaliation
Recreational and Social Activities
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection. The following action was taken:

21 WN
4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.78(2)(c),(d),(g),(q) The package of information shall include, at a minimum, (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of resident; (d) an explanation of the duty under section 24 to make mandatory reports; (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; (q) an explanation of the protections afforded by section 26.

Findings:

1. The inspector conducted an interview with the Admission Coordinator on March 28, 2011 related to the home's admission package. The following was identified during the interview and upon review of the home's admission package.
    - The admission package did not include the long term care home's policy to promote zero tolerance of abuse and neglect of residents.
    - The admission package did not include an explanation of the duty under section 24 to make mandatory reports.
    - The admission package did not include notification of the long- term care home's policy to minimize the restraining of residents and how to obtain a copy of the policy.
    - The admission package did not include an explanation of whistle-blowing protections related to retaliation.

The licensee failed to ensure the required information was included in the package of information.

Inspector ID #:	188

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.79(3)(c),(g) The required information for the purpose of subsections (1) and (2) is, (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, (g) notification of the long-term care home's policy to minimize the restraining of resident, and how a copy of the policy can be obtained.

Findings:

1. The inspector observed the following not posted within the long-term care home on March 22, 2011.
    - The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
    - The 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.

The licensee failed to ensure the required information was posted within the home.

Inspector ID #:	188

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.20(2)(d), (h) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (d) shall contain an explanation of the duty under section 24 to make mandatory reports, (h) shall deal with any additional matters as may be provided for in the regulations.

Findings:

1. The inspector reviewed the homes policy titled "RESIDENT ABUSE" and determined the following was not included.
   - The policy did not include an explanation of the duty under section 24 to make mandatory reports.
   - The policy does not identify the training and retraining requirements for all staff, including, training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations, as required as provided for in the regulations.

   The licensee failed to ensure their policy titled "RESIDENT ABUSE" contained the required information.

Inspector ID #:	188

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s. 50(1)3 The skin and wound care program must, at a minimum, provide for the following: #3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

Findings:

The home did not provide strategies for transferring and positioning residents to reduce pressure and prevent skin breakdown and reduce and relieve pressure as indicated by:

1. Three residents currently residing in the home, who are identified as risk for skin breakdown, were observed sitting in their wheelchair's with transfer slings still in place.

Inspector ID #:	158, 106

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.15(2)(a) Every licensee of a long-term care home shall ensure that, (a) the home, furnishings and equipment are kept clean and sanitary.

Findings:

1. During a walk-through on March 29, 2011 of the second floor inspector 188 observed and noted the following equipment not kept clean and sanitary:
   - Two sit to stand lifts in the west hallway had a build up dirt particles and stains on the foot plates, handles and legs of the lift.
   - Five resident wheel chairs had a build up of dirt particles on the foot plates, wheels and lower parts of the wheelchairs (w/c). Dried food particles were observed on two of the five resident w/c.
2. During a walk-through on March 21, 2011 of the home, inspector 158 observed and noted the following equipment and areas of the home not kept clean and sanitary:
   - The sit to stand lifts found on all floors had a build up of dirt particles on the foot rests and wheels
   - Ten residents' wheel chairs randomly observed had dirt build up
   - Five randomly observed residents' wheel chair table top trays were sticky with debris.
   - Dirt particles and dust build up in corners and at floor boards of halls was observed by inspector 158 at 15:30h on March 21, 2011on two of the three floors
   - A resident's wheelchair table top tray was noted to be sticky with debris at on March 24, 2011.

Inspector ID #:	188, 158

WN #6: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(10)b The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

Findings:

1. Inspector 188 reviewed the health care record for a resident on March 29, 2011. This resident returned to the home from the hospital with a new diagnosis and new medication orders. The plan of care for this resident did not include this new diagnosis or new medication use. The plan of care was not reviewed and revised when this resident's care needs changed following re-admission from hospital. The licensee failed to ensure a resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.

2. Inspector 158 reviewed the plan of care for a resident on March 31, 2011. The plan of care identifies that this resident uses a call bell. A resident assessment protocol (RAP) was previously completed for this resident. This cognition RAP indicates this resident does not use a call bell. The plan of care was not reviewed and revised when the care set out in the plan is no longer necessary. The licensee failed to ensure a resident is reassessed and the plan of care reviewed when the resident's care needs change or the care set out in the plan is no longer necessary.

Inspector ID #:	188, 158

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 ensuring that all resident's are reassessed and the plan of care reviewed and revised when the care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg. 79/10, s.129(1)(a) 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

Findings:

1. Inspector 188 observed the following bottles or cards of expired medications stored in the second floor medication cart on March 28, 2011:
   - Ferrous Gluconate 300mg, expired March 2010, 1 bottle
   - Acetaminophen 325mg, expired November 2010, 1 bottle
   - Soflax 100mg, expired October 2009, 1 bottle
   - Nitro spray, expired January 2010, 1 bottle
   - Sod Bicard 325mg, expired January 2011, 1 card
   - Ativan 1mg, expired February 2011, 30 tabs in card
   - Ativan 1mg, expired January 2011, 21 tabs in card

   The licensee failed to ensure that drugs are stored in a manner that complies with manufacturer's instructions for the storage of drugs.

2. Inspector 188 observed the following bottles of expired medications stored in the third floor medication cart on March 28, 2011:
   - Acetaminophen 325mg, expired November 2010, 1 bottle
   - Soflax 100mg, expired August 2010, 1 bottle

The licensee failed to ensure that drugs are stored in a manner that complies with manufacturer's instructions for the storage of drugs.

3. Inspector 106 observed the following expired medications stored in the government stock room (third floor) on March 24, 2011:
   - Soflax 100mg, expired August 2010, 8 bottles
   - Bronchophan Expectorant: Expired October 2010, 2 bottles

   The licensee failed to ensure that drugs are stored in a manner that complies with manufacturer's instructions for the storage of drugs.

4. Inspector 177 observed the following expired medications stored in the second floor medication room on March 24, 2011:
   - Tylenol Plain, expired November 2010, 1 bottle
   - Soflax 100mg, expired August 2010, 2 bottles
   - Artificial Tears, expired May 2011, 1 bottle

   The licensee failed to ensure that drugs are stored in a manner that complies with manufacturer's instructions for the storage of drugs.

5. Inspector 158 observed a medication pass. The inspector observed the registered practical nurse (RPN) leave the cart unattended and unlocked in the hallway twice while returning to the nursing station. Inspector observed the RPN leave the cart unattended and unlocked in the hallway an additional two times while administering medications in the dining room. The cart was not within the RPN's line of sight while in the dining room. The licensee failed to ensure drugs are stored in a medication cart that is secure and locked.

6. Inspector 106 observed a medication pass. The inspector observed the RPN leave the medication cart unattended and unlocked in the hallway on three occasions. The RPN was attending to resident care during these occasions and the cart was not in the RPN's line of sight. The licensee failed to ensure drugs are stored in a medication cart that is secure and locked.

7. Inspector 106 observed the RPN leave the medication cart unattended and unlocked for three minutes while administering medications in a resident's room. The licensee failed to ensure drugs are stored in a medication cart that is secure and locked.

8. Inspector 106 observed the RPN leave the medication cart unattended and unlocked in the hallway for six minutes while assisting a resident in the washroom. The licensee failed to ensure drugs are stored in a medication cart that is secure and locked.

9. Inspector 188 observed the RPN leave the medication cart unattended and unlocked in the hallway on several occasions while administering medication in residents' rooms. On one occasion the medication cart sat unlocked and unattended in the hallway for three minutes while the RPN was in a resident's room with the door closed. The licensee failed to ensure drugs are stored in a medication cart that is secure and locked.

10. Inspector 177 observed that the door to the second floor medication room was open, and the room was unattended. The inspector observed that the medication cart was in the medication room and was also unlocked and unattended. Medications were observed lying on the counter. The licensee failed to ensure drugs are stored in a medication room that is secure and locked.

Inspector ID #:	188, 158, 106, 177

Additional Required Actions:
VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area that is secure and locked and stored according to manufacture's directions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg. 79/10, s.8(1)(b) Where the Act of 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, (b) is complied with.

Findings:

1. The licensee did not ensure that the long-term care home complied with their Maintenance Department Policy, PMP-02.01 in the maintenance manual, regarding responsibilities. The resident area checklist for resident room walls states that resident walls are to have spot painting and spot repairs annually. The resident area checklist for resident room ceilings, flooring and doors states that doors need to be checked annually to ensure door finish is undamaged.
    - On March 31, 2011, the Support Services Manager, reported to inspector 106 that room 417 was last "patched and painted" in July, 2009.
    - Room 417 was observed by inspector 106 on March 28, 2011 to have wall gauges and scuff marks behind the bed closest to the window. The lower wall near doors had multiple scuffmarks and gouges in wall.
    - Room 417 was observed by inspector 106 on March 28, 2011 to have closets and washroom doors with horizontal scratches that cover the lower width of doors and the door moldings have paint that is chipped and metal is visible..

2. The Infection Control Manual, policy Hand Hygiene 02-05 states: "Hands are to be washed upon arrival at work and regularly throughout the work shift. Particularly hands should be washed or hand hygiene performed in the following circumstances: (a) Before or after any care; (b) Before and after breaks especially when eating; (c) After using the washroom; (d) After blowing your nose, coughing or sneezing (e) Before and after removing gloves or Personal Protective Equipment; (f) After touching any high touch surfaces such as keyboards, door knobs, elevator buttons, touch computer screens (POC tablets and e-Mar screens), etc.;(g) Before and after feeding a resident";
    - Inspector 177 observed the RPN administering medication to a resident. The resident spat two pills out onto the floor. The RPN paused from administering the meds, picked up the two pills, placed them in the paper cup, then gave the resident a drink. The RPN did not perform hand hygiene between picking the pills up from the floor and giving the resident a drink.

3. The Infection Control Manual, policy Contact Precautions 03-10 states: "Staff caring for residents who are on contact precautions will wear personnel protective equipment (PPE) as required. The following outlines when PPE is to be used. Gloves – When entering a room for any care. Gown – When there is direct contact with the resident for care and there is any risk of contamination of staff clothing/uniform."
    - Inspector 177 observed two PSWs providing care for a resident, who was on contact precautions. Neither PSW was wearing gowns or gloves while they provided personal-care. These two PSWs failed to comply with the policy for Contact Precautions.
    - Inspector 188 observed a PSW was providing personal care to a resident on contact precautions. The PSW was only wearing gloves. No other personal protective equipment was being used while providing care to this resident. This PSW failed to comply with the policy for Contact Precautions.

Inspector ID #:	158, 106, 177, 188

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 ensuring all policies, procedures and programs within the home are complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg. 79/10, s. 122(1)(b) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131(7) unless the drug, (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

Findings:

1. Inspector 188 observed two bottles of medication in the second floor medication cart and one bottle of medication in the second floor medication room storage. These bottles of medication did not contain a pharmacy label and were not received from the pharmacy service provider or the Government of Ontario. They were brought into the home by two residents' family members, as confirmed by the RPN. The licensee failed to ensure that no drug is acquired, received or stored by the home unless it has been provided by the pharmacy service provider or the Government of Ontario.

2. Inspector 188 observed medications in the third floor medication cart with a resident name on them. These medications did not contain a pharmacy label and were not received from the pharmacy service provider or the Government of Ontario. They were brought into the home by the resident's family members, as confirmed by the RPN. The licensee failed to ensure that no drug is acquired, received or stored by the home unless it has been provided by the pharmacy service provider or the Government of Ontario.

Inspector ID #:	188

WN #10: The Licensee has failed to comply with O.Reg. 79/10, s.32 Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

Findings:

1. The licensee did not ensure that a resident received individualized grooming on a daily basis.
    - Two residents who require staff assistance for personal care were observed to be unshaven on several dates through out the inspection.

Inspector ID #:	106

WN #11: The Licensee has failed to comply with O.Reg. 79/10, s.17(1)(a) 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.

Findings:

1. Inspector 188 observed a resident in bed. The head of this resident's bed was raised and the call bell was attached to the top of the mattress. This resident was positioned on their side and call bell was not within reach. The licensee failed to ensure the resident-staff communication and response system can be accessed and used by residents at all times.

2. A resident was observed by inspector 106 in their wheelchair and the resident's call bell was observed to be out of resident's reach clipped to a light cord against the wall side of the bed. The licensee failed to ensure the resident-staff communication and response system can be accessed and used by residents at all times.

Inspector ID #:	188, 106

WN #12: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)8 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.

Findings:

1. Inspector 188 walked into a room accompanied by a resident. Upon entering the room the inspector and the resident observed the resident's roommate receiving personal care. The PSW providing care then attempted to pull the privacy curtain. The PSW did not provide privacy to this resident while providing personal care.

2. Inspector 158 observed that a resident was receiving care from the Foot Care Nurse. The door to the room was open and the privacy curtain was not pulled. The licensee failed to ensure this resident received privacy during treatment.

3. Inspector 106 observed that the RPN administered eye drops to a resident in the dining room. The RPN was also observed to test a resident's blood sugar and administer insulin to the resident's left deltoid in the dining room. The RPN did not provide privacy to these residents.

Inspector ID #:	188, 158, 106

WN #13: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7) The licensee shall ensure that the care is provided to the resident as specified in the plan.

Findings:

1. Inspector 188 reviewed the care plan for a resident. Under a section titled falls it identifies specific interventions for call bell placement. Inspectors 188 and 106 noted that the resident's call bell was not placed according to the outlined intervention in the plan of care. The licensee failed to provide care to this resident as specified in the plan.

2. The home's mechanical lift procedure under "the Safe Lifting Program" #28 identifies the following: "Use 2 staff members to remove sling underneath resident. Exception: if care plan states that sling must be left under resident, ensure sling is crease free and positioned properly to avoid pressure."

3. Inspector 106 observed three residents sitting in their wheelchairs with transfer sling still in place. The plan of care for these three residents does not identify the sling may be left under the resident. The licensee failed to provide care to these resident's as specified in their plans.

Inspector ID #:	188, 106, 158

WN #14: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.15(2)c Every licensee of a long-term care home shall ensure that, (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. Inspector 158 observed the home, furnishings and equipment are not maintained in a good state of repair based on the following observations on March 28, 2011:
   - Fourth floor dining room contains floor tiles that are cracked
   - Multiple floor tiles outside of the fourth floor elevator are missing or cracked.
   - Room 304, the walls are gouged which can be seen from the hallway
   - Room 406, the walls are scratched and gouged.
   - The hallways walls on third and fourth floor are scratched and require painting.

- The ceiling tiles in the west side hallway on third and fourth floor contain stains
- The cupboards in dining/ Activity Area on all floors are chipped, scratched and require painting

2. Inspector 106 observed the home, furnishings and equipment are not maintained in a good state of repair based on the following observations on March 28, 2011:
   - Room 417 was observed by inspector 106 on March 28, 2011 to have wall gauges and scuff marks behind the bed closest to the window. The lower wall near doors had multiple scuffmarks and gouges in wall.
   - Room 417 was observed by inspector 106 on March 28, 2011 to have closets and washroom doors with horizontal scratches that cover the lower width of doors and the door moldings have paint that is chipped and metal is visible.

3. Inspector 177 observed the home, furnishing and equipment are not maintained in a good state of repair based on the following observations on March 30, 2011:
   - Room 214, scratches observed on the door;
   - Second floor tub room, damaged trim observed on the door;
   - Second floor shower room, walls observed to be scratched;
   - Second floor family/visiting room, trim around the floor observed to be damaged, the walls observed to be scratched and the door was scratched.

Inspector ID #:	158, 106, 177

WN #15: The Licensee has failed to comply with O.Reg. 79/10, s.229(4) The licensee shall ensure that all staff participate in the implementation of the program.

Findings:

1. Infection control practices were not implemented as indicated by the following observations made by inspector 158 on March 25, 2011 at 10:30h, fourth floor. Care carts used to dispose soiled linen were not available on the fourth floor (east side) on March 25, 2011 at 10:30h. A student RPN was observed to be looking for the soiled linen cart by entering each resident's room while carrying soiled linen previously used for a resident's continence care. The student's action was observed by the RPN, HCA, and housekeeper working on this unit. The home's nursing staff did not re-direct the student.

3. Infection control practices were not implemented by staff as indicated by the following observations made by inspector 158. The RPN who was administering treatments (i.e. eye drops and puffers per aero chamber) did not wash their hands between administering treatments to multiple residents. There was no hand cleaning solution noted on the medication cart.

4. Infection control practices were not implemented by staff as indicated by the following observations made by inspector 158. Inspector observed the room of a resident who was positive for MRSA.
   - The red isolation bag and garbage bag was not in place in the cart provided for this resident in their room.
   - There was no signage identifying the presence of or the type of isolation in the semi-private room
   - A dried brownish soiled face cloth lay in the corner of the room by the cart.

5. Infection control practices were not implemented as indicated by observations made by inspector 158 during a medication pass:
   - Observed the RPN using teeth to open medication packages
   - The RPN did not wash hands between multiple residents the RPN was administering medications to between 11:00h until 12:30h

- The RPN did not wash hands after assisting a resident to open their mouth with the RPNs hands.
- The RPN did not wash hands between residents receiving treatments (i.e. puffers and eye drops).

6. Infection control practices were not implemented as indicated by observations made by inspector 106 during a medication pass. The RPN was observed to:
   - Not wash hands during the entire medication pass. The RPN was observed to provide medication and treatments to a total of 21 different residents.
   - Place medication directly into two resident's mouth with the RPN's hands. The RPN was not observed to wash hands either before or after administering medication to either resident.
   - Open a medication package with the RPN's teeth.

Inspector ID #:	158, 106

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 ensuring all staff participate in the infection control program, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 3(1)(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.

Findings:

1. Inspector 158 observed that residents' were not treated with courtesy and respect and in a way that respects the residents' dignity. The inspector observed on March 22, 23 and 31, 2011 that various resident care equipment (i.e. care carts and sit to stand lifts) were parked in multiple resident's rooms while not in use. The licensee failed to ensure residents were treated with courtesy and respect and in a way that respects the residents' dignity.

2. Inspector 158 observed that two students and a PSW were toileting a resident. The bathroom door was opened exposing the resident's lower unclothed body to both the inspector and a RPN who had entered the room. A roommate was also in the room at this time. The licensee failed to ensure residents are treated in a way that respects their dignity.

3. Inspector 158 observed the RPN administer medications to two residents while they were on the toilet. The licensee failed to ensure these residents were treated with courtesy and respect and in a way that respects the residents' dignity.

4. Inspector 188 observed a resident multiple times in the dining room. This resident was observed with her hair disheveled and visible facial hair on her chin and jaw line on these three occasions. The licensee failed to ensure this resident was treated with courtesy and respect and in a way that fully respects her dignity.

5. Inspector 188 observed a resident in the dining room. This female resident had long facial hairs, approximately two centimeters, on her chin and jaw line. These hairs where visible to the inspector while sitting across the table from the resident. The licensee failed to ensure this resident was treated with courtesy and respect and in a way that fully respects her dignity.

Inspector ID #:	158, 188

WN #17: The Licensee has failed to comply with O.Reg. 79/10, s.89(1)c As part of the organized program of laundry and services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours.

Findings:

The home's linens are not kept in a good state of repair as indicated by the following:

1. Inspector 158 observed on March 22 and 23, 2011 that the fitted bed sheet on beds in rooms 417 b4, 405, 415 b2, 420, 415 b1, and 412 b1 were thread bare and with holes.

Inspector ID #:	158

WN #18: The Licensee has failed to comply with O.Reg. 79/10, s.37(1)(a) 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) labeled within 48 hours of admission and of acquiring, in the case of new items.

Findings:

1. Inspector observed the following unlabelled resident personal items:
   - March 25, 2011 at 10:23h, two used, unlabelled nail clippers located in the second floor shower room.
   - March 28, 2011 at 10:32h, a used comb in the cupboard in the second floor tub room.
   - March 28, 2011 at 10:38h, a wooden brush, a burgundy pick, a black pick and a stick of deodorant, all observed in a cupboard in the second floor shower room.

   The licensee failed to ensure each resident of the home has his or her personal items labeled.

Inspector ID #:	177

WN #19: The Licensee has failed to comply with O.Reg. 79/10, s. 229(10)3 The licensee shall ensure that the following immunization and screening measures are in place: #3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Findings:

The home has failed to offer immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. This is supported by the following findings:

1. On March 21, 2011 inspector #177 reviewed the health care records of four residents. The inspector identified that none of these residents had a record of receiving or being offered the Tetanus or Diphtheria vaccination. (TD)

2. On March 28, 2011 at 11:00h, inspector 177 interviewed the Infection Control Practitioner, to obtain information regarding immunization practices. The following information was provided: New residents are offered the TD vaccination on admission. These vaccinations have not yet been offered to all the existing Long Term Care residents.

Inspector ID #:	177

WN #20: The Licensee has failed to comply with O.Reg. 79/10, s.131(2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:

1. The licensee did not ensure that a drug was administered to a resident as prescribed for the resident as indicated by:
   - The doctor ordered a medication to be administered at 08:00h to a resident
   - The RPN was observed by inspector 158 to give this medication at 11:30am.

Inspector ID #:	158

WN #21: The Licensee has failed to comply with O.Reg. 79/10, s.114(3)(a) The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Findings:

1. Inspector 188 reviewed homes policy titled "Drug Destruction and Disposal" Policy 5-4. Procedure # 14 identifies in relation to storage of discontinued narcotics "Retain in a double-locked area within the home, separate from those medications available for administration to a resident."
   - March 30, 2011 upon review of the narcotic storage area in the medication room on second floor the RPN and inspector 188 identified three cards of discontinued narcotics that were being stored in the locked area as narcotics available for administration to a resident. The licensee has failed to ensure their policy titled "Drug Destruction and Disposal" was implemented.

2. The home did not ensure that the procedure identified in Medelink Med Pass 5.5, "Documenting an Administration Requiring a Location" was implemented as indicated by:
   - Electronic Medication Administration Record (EMAR) for a resident was reviewed by inspector 158 on March 24, 2011. Demarcation of site location for the subcutaneous injection was not documented when administered.
   - EMAR for a resident was reviewed by inspector 158 on March 24, 2011. Demarcation of site location for the subcutaneous injection was not documented when administered.

Inspector ID #:	188, 158

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). April 18, 2011