Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2016	2016_287548_0008	008134-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

RUZICA SUBOTIC-HOWELL (548), ANANDRAJ NATARAJAN (573), GILLIAN CHAMBERLIN (593), PAULA MACDONALD (138), RENA BOWEN (549)

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): April 4,5,6,7,8,11,12,13,14 and 15, 2016

Concurrently the following Logs# were inspected:
-related to complaints:
034060-15, 000229-16 and 001431-16 to resident care and,
008061-16 related to resident care and hydration and nutrition

related to allegations of abuse- 006475-15 and 026951-15, 027629-15, 028572-15, 030953-15 and 033199-15
-related to allegation of neglect- 034998-15
-related to falls prevention- 005201-16
-related to skin and wound prevention- 034327-15 and 013864-15
-related to unexpected death- 035987-15

During the course of the inspection, the inspector(s) toured resident care areas, reviewed residents' health care records, observed infection control practices, environmental services policies, reviewed menus, internal incident & investigation documentation, reviewed resident personal equipment cleaning schedules, observed residents meal service and nourishments, and observed medication administration and associated policies, reviewed maintenance program and records.

During the course of the inspection, the inspector(s) spoke with the Residents, Family members, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC),Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Support Services Manager, Dietary Support Worker,Housekeeper, Registered Dietitian, Resident's Council, Chair of the Family Council, Receptionist, Laundry Aide, Dietary Aide (DA), Physiotherapist (PT), Physiotherapist Assistant (PTA), Registered Practical Nurse (Infection Prevention and Control) and Food Services Manager.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to the resident.

The resident #052's family member is concerned that the resident's portable oxygen tank has been found empty on several occasions.

Inspector #549 reviewed resident #052's health care record.

Resident #052 was admitted to the home on a specified day in December 2015, with portable oxygen and co-morbidities.

Resident #052's physician's orders on admission indicated the resident is to have

continuous oxygen running.

Resident #052's progress notes dated on admission indicated that the resident was seen by Medigas. The Medigas form on the resident's health care file indicates that the resident was provided with an oxygen concentrator in his/her room and a portable canister for use when out of the resident's room.

Resident #052 was assessed on a specified day in January 2016, in the emergency department with a diagnosis of possible diminished oxygenation. Resident #052 returned to the home the same day with follow-up instructions for continuous oxygen to keep the oxygen saturation greater than 88%.

On April 13, 2016, the ADOC and Inspector #549 reviewed the written plan of care for resident #052 for a specific time period between December 2015 to January 2016. The written plan of care for the noted time period did not include resident #052's oxygen care needs.

In summary the plan of care did not set out clear directions to staff and others who provide direct care to the resident related to the resident's oxygen care needs. Related to Log # 000229-16.[s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1) (c) in that the licensee did not 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.

Resident #059 was admitted to the home on a specified day in April, 2015, with multiple diagnoses including dementia. Resident #059's health care records identified the resident to be at high risk for falls.

According to the most recent MDS RAI assessment conducted on a specified day in January, 2016 in the last seven calendar days, physiotherapy treatments were administered three days for 60 minutes.

Inspector #573 reviewed the resident's physiotherapy plan of care for fall prevention. It indicated that the resident is in physiotherapy treatment for multiple interventions, but the plan of care does not identify the frequency of the physiotherapy treatments that is to be provided to the resident #059.

Inspector reviewed resident #059's recent physiotherapy quarterly assessment for a specified day in January 2016. The resident's quarterly physiotherapy assessment indicated the frequency of physiotherapy visits is two to three times per week.

On April 13, 2016, Inspector #573 spoke with physiotherapy assistant (PTA) #137 who indicated that resident is seen one to two times per week for physiotherapy treatment.

Inspector reviewed resident #059's physiotherapy daily attendance sheet for the month of February and March 2016, which indicated the resident was provided with physiotherapy treatments one to two times per week. Inspector #573 reviewed the resident #059's written plan of care, progress notes and assessments. There is no documentation either by the physiotherapist or physiotherapy assistant regarding the decrease in frequency of physiotherapy treatments that occurred between January 2016 and March 2016.

On April 13, 2016, the home's physiotherapist indicated to Inspector #573 that resident #059 is currently on physiotherapy treatments. Furthermore, the physiotherapist indicated that the PTA is to provide two times per week for physiotherapy treatment unless the resident refuses treatment or is absent.

The resident written plan of care for the physiotherapy does not set out clear directions to the physiotherapy assistants and staff who provide direct care to the resident regarding the frequency of the physiotherapy treatments that were delivered to resident. [s. 6. (1) (c)]

3. The licensee has failed to comply with section 6(5) of the Act in that the licensee failed to ensure that the resident's substitute decision maker (SDM) is given the opportunity to participate fully in the development and implementation of the resident's plan of care.

The home submitted a Critical Incident Report to the Director related to the unexpected death of resident #048 that occurred in December, 2015. Inspector #138 reviewed resident #048's health care record and noted that on the day of the resident's death there was a progress note from RPN#120 that described the RPN's assessment and the resident's change in condition. There was no progress note entry indicating that the resident's SDM was made aware of the changes in the resident's condition. Resident #048 later passed away in the home during the evening shift.

The Inspector spoke with RPN #120 regarding the care of Resident #048 on the day the

resident passed away. RPN #120 stated that he recalled this shift and stated that Resident #048 had trouble eating, remained in bed, and could not take the morning medications. RPN #120 stated that he assessed the resident as a result of these observations and after informing RN#121. The RPN further stated that the resident was assessed mid-morning after the medication pass and was found with a change in condition. When asked by the Inspector, RPN #120 responded that he had not informed the SDM of the change in condition of Resident #048. The Inspector also spoke with RN #121 for the day shift, RN #123 for the evening shift, and RPN #122 for the evening shift, all who worked the day the resident passed away. All stated that the each had not informed the SDM of the change in Resident #048's condition. RN #123 and RPN #122 stated to the Inspector that the SDM was informed once the resident ceased to breathe. Log 035987-15

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #036 is dependent on staff for activities of daily living and is identified as high risk for falls. Fall prevention interventions were specified in the care plan on a specified day in February 2016. The resident's care plan specified that a seat belt be applied for safety while the resident was in the wheelchair.

Progress notes, assessments, physician orders and consent form were reviewed. Resident #036 was assessed to require a seat belt while in a wheelchair. The POA consented and the physician ordered the seat belt on a specified day in January, 2015.

On April 14, 2016 PSW #132 and physiotherapist PT #134 both indicated they were aware the resident #036 was identified as high risk for falls.

During record review it is documented on a specified day in February, 2016 that resident #036 had a witnessed fall incident in the dining room. The post fall assessment indicated a PSW was not aware of and did not apply the required seat belt.

As such, the care related to resident #036 needs for a seat belt as specified in the plan of care was not provided. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #044 as specified in the plan.

On April 15, 2016 at 1310 hours, Inspector #593 observed resident #044 asleep in their bed, the head of the bed was down and there was a tray meal on the residents bedside table. The tray meal consisted of a hot meal that was covered in plastic wrap, a pudding, a hot beverage and an apple juice.

On April 15, 2016 during an interview with Inspector #593 PSW #138 reported that they left the tray meal on the resident's bedside table. The PSW was unaware of the process regarding this resident receiving tray meals and asked Inspector #593 whether they should wake the resident or take away the tray. PSW #138 reported that they assumed that another staff member would come to assist the resident and that they would wake the resident and remove the plastic wrap from the meal.

On April 15, 2016 during an interview with Inspector #593 the Food Service Manager reported that there was one PSW on each floor that was responsible for the tray meals. They added that, it was the responsibility of this PSW to ensure that the resident was awake and that they received the level of assistance that they required.

A review of resident #044's progress notes found an entry related to an interdisciplinary team conference that was held on a specified day in April, 2016, with the resident's POA and other family present. The progress note indicated that the home was aware that food was being left in the resident's room without ensuring the resident was awake to eat it and that the policy would be enforced. In addition, resident #044's current care plan specified that staff are to ensure the resident is awake and positioned and food is set up for tray service.

On April 15, 2016 during an interview with Inspector #593 RPN#139 reported that they were present during the team conference and as a result of the family's concerns they updated resident #044's care plan. RPN#139 further reported that it was the expectation of the home that the staff leave the tray meal only if the resident was awake, if he was asleep, they are not to leave the tray but to come back later. If the resident was awake, the staff were required to unwrap the food and set up for the resident. [s. 6. (7)]

6. The licensee has failed to ensure that resident #059 is reassessed and the plan of care reviewed and revised at any other time when resident's care needs changed.

Resident #059 was admitted in the home on a specified day in April 2015, with multiple diagnoses, including dementia. Resident #059's health care record identified the resident

is at high risk for falls. Further, it indicated that resident was in physiotherapy treatment for fall prevention.

As per a critical incident report on a specified day in January 2016, resident #059 had an unwitnessed fall which resulted in injury.

Review of resident #059 health care records indicated the resident's care needs changed after the fall incident that occurred on a specified day in January 2016. Two days post-fall a referral was sent to the home's physiotherapist for resident #059's change in condition due to the injury. Inspector #573 reviewed resident #059 health care records and there is no documentation regarding any reassessments that was done by the physiotherapist when the resident's care needs changed.

Inspector #573 spoke with the Director of Care who indicated that resident #059's fall incident on a specified day in January, 2016, resulted in a change in the resident's care needs.

On April 13, 2016, the home's physiotherapist indicated to the Inspector #573 that a physiotherapy reassessment for resident #059 was not conducted after the resident fall incident which resulted in change in the resident care needs. [s. 6. (10) (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 the plan of care provides clear directions to staff and others who provide care to the resident, to ensure the resident's SDM is given an opportunity to participate fully in the development and implementation of the resident' s plan of care when there is a change in the resident's condition and, to ensure the care is provided to the resident as specified in the plan, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the emergency plan related to testing the emergency plan related to fires is complied with.

In accordance with S.O. 2007, Chapter 8, s.87 every Long Term Care home is required to have an emergency plan.

In accordance with O. Reg. 79/10, s. 230(7) the licensee is to test the emergency plan related to fires.

This finding is related to Log # 034060-15.

Resident #056's family member was visiting the resident on the second floor when the fire alarm in the home was activated. The resident's family member does not recall the date of the incident.

Resident #056's family member indicated that he/she felt there was no action on the part of the staff on the second floor when the fire alarm was activated. He/she indicated that the fire alarm was ringing for approximately six to eight minutes. Upon investigation he/she found the fire department was on site in the kitchen area of the home. He/she felt there was no organized plan of action from the staff on the second floor.

The home has developed a Fire Safety Plan as part of their Emergency Plan. The Fire Safety Plan was last updated March 2015.

On April 12, 2016 Inspector #549 reviewed the home's Fire Safety Plan. On page 1 of the Fire Safety Plan, Section 2.0 – Frequency: it indicated fire drills should simulate an

actual fire emergency and will be performed monthly on all shifts, in different locations and at different times.

On page 2 of the Fire Safety Plan Section 4.0 it indicated that a Report of the Fire Drill is to be completed for each fire drill.

On page 3 of the Fires Safety Plan, Section 6.0, it indicated all staff in attendance at the time of a fire drill will sign the Record of Fired Drill Attendance. All records of the fire drills must be kept for a minimum of two years and be part of a fire drill log book.

On April 12, 2015 the Administrator indicated to Inspector #549 that the home conducts one fire drill on each shift every month. The home has three shifts: days, evenings and nights.

The Administrator indicated to Inspector #549 that the Support Services Manager is responsible for home's fire drills and maintaining the records of the Report of Fire Drills and the Record of Fire Drill Attendance.

Inspector #549 reviewed the fire drill log for the time period of January to December 2015 and January, February and March 2016.

Inspector #549 was unable to locate the Report of Fire Drill for
the Record of Fire Drill Attendance for the month of September, November, and December 2015. The fire drill log book contained one Report of Fire Drill with no Record of Fire Drill Attendance for the month of October 2015, January (no year stamp), February (no year stamp) and two Report of Fire Drill with no Record of Fire Drill Attendance for March 2016.

During an interview on April 12, 2016 the Support Services Manager said to Inspector #549 that fire drills have not been conducted on each shift monthly.

During an interview with the Administrator on April 15, 2016 it was confirmed with Inspector #549 that the home did not conduct fires drills in accordance with the home's Fire Safety Plan. [s. 8. (1)]

2. The licensee has failed to ensure that the food and fluid intake monitoring policy was complied with.

A review of resident #041's food and fluid intake monitoring records for a specific period in April, 2016, found that the resident's fluid intake was below the requirement as per the resident's hydration care plan for all 12 days reviewed.

A review of resident #041's current care plan, found that the resident had specified nutritional requirement.

A review of resident #073's food and fluid intake monitoring records for a specific period in April, 2016, found that the resident's fluid intake was below the requirement as per the resident's hydration care plan for all 12 days reviewed.

A review of resident #073's current care plan, found that the resident had a specified nutritional requirement.

A review of resident #074's food and fluid intake monitoring records for March and April, 2016, found that the resident's fluid intake was below the requirement as per the resident's hydration care plan for 10 consecutive days out of the 12 days reviewed.

A review of resident #074's current care plan, found that the resident had a specified nutritional requirement.

A review of the home's policy titled "Food and Fluid Intake Monitoring" #RESI-05-02-05, revised September 2014, found that Registered Staff are to review resident food and fluid intake records daily and if a resident consumes less than their minimum fluid target for three consecutive days, the resident requires a hydration assessment. The hydration assessment must be documented.

A review of resident #041, #073 and #074's health care records found no documented hydration assessments.

On April 13, 2016 during an interview with Inspector #593, the home's Registered Dietitian #130 reported that a member of the registered nursing staff was supposed to complete a hydration assessment if a resident was below their recommended fluid intake for three consecutive days. They further reported that the evening nurse was supposed to tally the resident's fluid intake at the end of each day and then compare it to the resident's fluid requirement.

On April 15, 2016 during an interview with Inspector #593 the ADOC reported that the

registered nursing staff should be aware of the policy to complete a hydration assessment when the resident is not meeting their fluid requirements. They added that they are currently in the process of providing re-education to staff regarding hydration and this would be included. Afterwards, the DOC confirmed that the hydration education is based on the homes policy. [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 the testing the emergency plan related to fires and food and, fluid intake monitoring are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with section 9.(1)2. of the legislation in that the licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by resident, and those doors must be kept closed and locked when they are not being supervised by staff.

On Monday, April 4, 2016, Inspector #138 was on the second floor which is a secured floor with wandering residents. The Inspector observed the door to the Lab Storage room to be closed but not locked and the Inspector was able to open the door and enter the room. Inside the room it was noted that there was no resident-staff communication response system (call bell) and that on the counter was what appeared to be a collected urine sample. The Inspector continued on the unit and observed that the door to the

Storage Room was slightly ajar which prevented the lock from being engaged, thus making the room accessible by pushing the door open. No staff were in the immediate area to supervise resident access to these rooms.

The Inspector was on the third floor that same day and observed the door to the Staff Lockers room propped open with a blue recycling box. The door to the Eye Wash Station room was also open. It was noted by the Inspector that there was no call bell in either room. It was also observed by the Inspector that there were no staff in the immediate area at this time to supervise resident access to these rooms.

On April 7, 2015, the Inspector was on second floor again and observed the door to the Storage Room to be propped open fully using a wood wedge. There were no staff in the area to supervise this room. The Inspector later observed PSW#125 enter the Storage Room through the opened door. The Inspector asked the PSW if the Storage Room was a resident accessible area and she stated that it was not. PSW #125 then ensured the door to the Storage Room was pulled closed and locked. The Inspector later spoke with RPN#124 regarding the Storage Room and she also stated that it was not a resident accessible area.

On April 8, 2016, the Inspector toured all resident living areas in the building and noted on second floor that the door to the Storage Room was once again ajar and not locked. The door to the Lab Storage room was also closed but still not locked. On the fourth floor, the Inspector observed the door to the Eye Wash Station room to be fully opened and it was noted that the room did not have a call bell. On the fifth floor, the Inspector observed the door to the Soiled Utility room was not closed tight enough to engage the lock on the door and the Inspector was able to push the door open and enter the room. In all cases, staff were not present to supervise these doors.

The Inspector spoke with the Director of Care who stated that the rooms mentioned above are not resident accessible rooms and that she would follow up regarding these doors. [s. 9. (1) 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 all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that, the home's communication and response system was maintained in a safe condition and in a good state of repair.

During stage one of the RQI, the communication and response system in multiple resident rooms were found to be in disrepair on levels two and four of the home. The communication and response system on these two levels of the home in the washrooms consists of a plate that is attached to the wall, the plate has a switch that when switched to the down position, the system is engaged and a call has been placed. A black plastic cap is secured over the switch and a cord is attached to this cap. The cord is thread through a hole anchored at the base of the plate which ensures the cord is kept close to the wall and encourages users to pull downwards which engages the system and places a call. The cord has a red plastic toggle at the end, which can be used to grip the cord when placing a call.

Further inspection of these home areas April 7 to 12, 2016, found the following:

Room 243- the black cap was very loose, dislodged from the switch with little force. When the cord was pulled to place a call, the black cap dislodged and did not engage the switch. A call was not placed.

Room 256- the black cap was loose and when the cord was pulled to place a call, the black cap dislodged from the switch, the switch was not consistently engaged. Once the black cap had dislodged, it had to be manually replaced before a further call could be placed.

Room 242- the call bell system by the residents bed consists of a long grey cord with a red button at the end. To place a call, the red button is required to be pushed. Usually with this system the button will return to the original position therefore allowing future calls. In room 242, the red button is depressed in and stuck, to make the call required extra effort to locate the button as well as additional force to press the red button to activate the call.

Room 566- force was needed to pull the cord to activate the switch, when the cord was pulled, the black cap was dislodged from the switch. The switch was not consistently engaged, when the cord was pulled, the black cap had to be replaced before a further call could be placed.

Room 516- force was needed to pull the cord to activate the switch, when the cord was pulled, the black cap was dislodged from the switch. The switch was not consistently engaged, when the cord was pulled, the black cap had to be replaced before a further call could be placed.

Room 215- the cord was tied around the anchor at the base of the wall plate. As a result, when the cord was pulled, the switch did not engage and the call could not be made. For the cord to be tied around the anchor, part of the system has to be removed and then replaced.

Room 259- the cord was tied around the anchor at the base of the wall plate. As a result, when the cord was pulled, the switch did not engage and the call could not be made.

On April 8, 2016 during an interview with Inspector #593, in response to the tied call bells in rooms 215 and 259, RPN #140 reported that the cords should not be like that and

maintenance would be required to fix the issue. They confirmed that a resident would be unable to make a call with the cords tied to the anchors.

On April 8, 2016 during an interview with Inspector #593, in response to the call bells in disrepair, RPN #141 reported that some of the call bells have been like this for some time and when they answer a call, they will find the switch hanging off the wall and they need to replace the switch before another call could be made. They added that something like this should be documented in the maintenance request book so that it could be fixed.

On April 11, 2016 during an interview with Inspector #593 the Support Services Manager #117 reported that they have previously seen a cord tied to the anchor point in one of the dining rooms and that when this was done, the residents are unable to place a call when the cord is pulled. In response to the call bells in disrepair, #117 reported that the call bells are part of the preventative maintenance schedule which is completed either monthly or quarterly by maintenance which includes checking the cords, the switches and the plates. #117 further reported that upon discovery of the issue by staff, this should be documented in the maintenance request book, but he is not certain that this would be done.

A review of the home's policy titled "Maintenance Inspection Checklist Procedure #1200", last revised July 2013, for the Nurse Call system, documented to check that all call cords are in place, check the function of the following: control panel, initiating devices and replace defective components as necessary.

A completed copy of the Maintenance Inspection Checklist #1200 was reviewed, items recorded related to the communication and response system between January 5, 2016 and April 5, 2016. In regards to the disrepair of switches, it was documented that one call switch was replaced in room 318 on February 9, 2016. [s. 15. (2) (c)]

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

The following home required repairs were observed on April 8, 2016 by Inspector #549.

Second Floor
-resident washroom room # 209 the sink counter has approximately a four inch piece of laminate missing along the side, the front of the counter has several chunks missing with jagged edges. The missing laminate and areas of chunks missing are exposing the

porous material underneath. To the right side of the toilet on the back wall there is a piece of vinyl baseboard sitting on the floor, the exposed section of gyproc approximately twelve inches by four inches is crumbling and falling on the floor.

-resident washroom #210 has approximately two inches of laminate missing on the right side of the sink counter exposing porous material.

-resident washroom #226 has a metal clip that is approximately three inches long and a quarter inch wide screwed to the side of the sink counter. The metal clip has sharp edges and is rusted. Staff on the unit was not able to identify what the clip is used for.

-resident washroom #266 the caulking around the top of sink counter is cracked and peeling from the wall.

-resident washroom #252 the left side of the sink counter is missing the piece of laminate the whole length of the counter, exposing porous material. The front right side of the sink counter has a two inch chunk missing which is jagged and exposing porous material.

-resident washroom #256 the light over the sink is cracked. There is a gap of approximately half an inch between the wall and the top of the sink counter.

-resident washroom #259 there is an area at the back of the toilet above the toilet seat shoulder height approximately twelve inches long and one inch wide where the building framing metal is exposed. The front of the sink counter is constructed of wood which is cracked and bubbling. The cracked area and the bubbling area have no finish left on them exposing porous material.

-resident washroom #267 and #268 have a one inch piece of laminate on the side of the sink counter missing, exposing porous material.

Third floor
-resident washroom #314 the sink counter front panel is constructed of wood. The wood panel has areas that have bubbled up exposing porous material. The paint on the wood panel has worn off in several areas exposing the porous material.

-resident washroom #320 the baseboard heater front cover has been damaged and is falling off.

-resident washroom #325 has a piece of laminate missing the length of the sink counter on the right side, exposing porous material.

Fourth floor
-resident washroom #420 the sink counter has a piece of laminate missing approximately one foot in length exposing porous material. The caulking around the sink itself is cracked. There is some visible brown coloured debris caught under the cracked caulking.

-resident washroom #455 there is a piece of laminate missing the length of the sink counter on the left side, exposing porous material

-resident washroom #463 the front panel of the sink counter is constructed of wood. There is an area approximately a quarter inch wide and two inches long that the sink does not hang over the wood panel exposing porous material.

Fifth floor
-resident washroom #516 has a piece of laminate missing along the side of the sink counter approximately two feet long, exposing porous material

-resident washroom #526 has a piece of laminate missing along the side of the sink counter approximately one inch , exposing the porous material.

On April 11, 2016 the Support Services Manager accompanied Inspector #549 to review the repairs required in room #259, #249 and #209.

On April 12, 2016, the Support Services Manager indicated during an interview with Inspector #549 that the home has a process in place for the reporting of maintenance repairs. Each home area has a maintenance log book in which staff complete a request for repairs for the home, furnishings and equipment. The maintenance workers are to check the maintenance log book on each floor daily. The maintenance worker will then complete the requested repairs or if unable to complete the repairs report to the Support Services Manager for further instructions.

Inspector #549 reviewed the maintenance log book on each floor for the period of December 2015 to April 14, 2016 and was unable to locate any requests for the repairs noted in the resident washrooms.

The Support Services Manager indicated to Inspector #549 on April 12, 2016 during an interview, that the staff are not completing the request for repairs form in the maintenance book related to the resident washrooms. He indicated that it is the responsibility of all staff to complete the request for repair form when disrepair in the home is observed. The Support Services Manager indicated during the same interview that he was not aware of all of the required repairs in the noted resident washrooms. [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 repairs and maintenance of the communication and response system and, to resident bathrooms, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres(cm).

On April 4, 2016, Inspector #138 observed the window in the conference room on the ground floor was able to be fully opened to approximately 60 cm. This room is connected to the Chapel and is therefore accessible to residents. The Inspector toured the building and noted that there were several similar windows on the ground floor including in the Chapel, manager offices, and the Activity Room, all of which could be opened fully.

The Inspector spoke with the Administrator who arranged to have the windows fixed so that they could not fully open. This work was completed prior to the end of the RQI. [s. 16.]

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 windows on the ground floor that are accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under the falls program, including interventions and the resident's responses to

interventions are documented.

Inspector #593 reviewed an email communication between the home and resident #043's family for a specified date in March, 2016 that documented multiple interventions relating to falls preventions. The interventions included the bed in the lowest position when the resident is in bed and floor mats, to protect him/her in the event he/she got up or rolled out of bed.

A review of resident #043's health care record, found no documentation related to the use of the above interventions, when the interventions were first implemented or whether the interventions had been effective.

A review of resident #043's health care record found that the resident had sustained 11 falls over a 12 month period. A post falls assessment was completed after each fall however, the outcome of each assessment did not list the use of any interventions related to falls preventions with each assessment documenting "care plan reviewed and no updates required".

A review of resident #043's most recent care plan found a focus related to falls, this was initiated on a specified day in September, 2015, after the resident had sustained two falls during the month. The falls assessment did not indicate any changes to the residents care plan as a result of the falls and the interventions related to the lowered bed and falls mats were still not documented in the assessments or the falls focus of the care plan. Resident #043's care plan documented that they are in the "Falling Star Program". Staff interviewed could not identify why the interventions were not captured in the post fall assessments.

A review of the Falling Star Program, which is part of the Falls Prevention and Management Program, found that any interventions related to this program will be implemented and documented in the resident care plan.

On April 15, 2016 during an interview with Inspector #593 the ADOC reported that the care plan for resident #043 documents that the resident is part of the falling star program and this infers that certain falls prevention interventions are in place however, the staff member refers to the DOC as they are responsible for falls prevention in the home.

On April 15, 2016 during an interview with Inspector #593,the DOC reported that a resident being part of the falling star program does not necessarily mean that there are

certain interventions are in place. The DOC added that for most residents as part of this program, they have a high/low bed and fall mats by the bed however, it should be documented in the residents care plan. [s. 30. (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 any action taken, interventions and resident responses with respect to the falls program are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative choices of beverages at meals for residents requiring thickened fluids.

On April 4, 2016, during the lunch meal service on level four, Inspector #593 observed a single thickened beverage provided to residents #041, #073 and #074. There were no other beverages offered or provided to these residents during this meal service. It was observed that for residents receiving thin fluids, they were being offered and provided two to three beverages each including milk, water, a variety of juices, tea and coffee.

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On April 13, 2016, during the breakfast meal service on level 4, Inspector #593 observed a single thickened beverage provided to residents #041, #073 and #074. There were no other beverages offered or provided to these residents during this meal service. It was observed that for residents receiving thin fluids, they were being offered and provided two to three beverages each including milk, water, a variety of juices, tea and coffee.

On April, 4, 2016 during an interview with Inspector #593,Dietary Aide #133 reported that the home used commercially prepared thickened juices in nectar and honey consistency. For all other thickened fluids, including milk and water, #133 reported that the PSW was responsible for thickening these for the resident at the point of service.

During an interview with Inspector #593, April 13, 2016, the Food Service Manager #135 reported that it was the expectation of the home, that all residents requiring thickened fluids were offered and provided the same beverage offerings as residents receiving thin fluids. [s. 71. (1) (d)]

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's menu cycle includes alternative beverage choice at meals for residents requiring thicken fluids, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures developed for addressing incidents of lingering offensive odours are implemented.

Inspector # 548 identified a resident room to have a lingering offensive odour on April 5, 2016 at 10:50.

Inspector # 549 identified a another resident room to have a heavy lingering odour on April 8, 2016 at 09:00hrs. Inspector #549 observed the housekeeping staff cleaning resident room including the washroom at 10:00 on April 8, 2016. Inspector #549 returned to the room and found the heavy lingering odour remained.

Inspector #138 identified a resident room with a strong lingering odour on April 5, 2016 at 10:10.Inspector #549 observed on April 8, 2016 at 09:00 the room to have a strong lingering odor in the shared resident room and in the hallway outside of the room. Inspector #549 observed the housekeeper cleaning the shared room including the washroom at 10:15. Inspector #549 returned to room at 10:30 to find that the room still had a very strong lingering odor going out into the hallway.

Inspector #549 observed the washroom in a specified room to have a lingering odour on April 4, 2016 at 13:00 hrs. Inspector #549 observed the washroom in same room on April 8, 2016 at 11:05 to have a lingering odour.

Inspector #549 observed the washroom in a specified room to a strong lingering odour on April 4, 2016 at 12:40 hrs. Inspector #549 observed the washroom in the same room to have a strong lingering odour on April 8, 2016 at 11:00 hrs.

During an interview with housekeeping staff #112 and #129 Inspector #549 was shown the product that is provided to housekeeping staff to manage lingering odours. Both housekeepers indicated that this is the only product they have to manage odours and were not aware of the home's procedure to manage lingering odours.

On April 11, 2016 the Support Services Manager accompanied Inspector #549 to two identified resident rooms. The Support Services Manager indicated to the inspector the he detected the lingering odour from two of the identified resident rooms.

During an interview on April 11, 2016, the Support Services Manager indicated to Inspector #549 that there is a procedure to deal with lingering odours. The homes policy #HL-05-03-08 titled Dealing with Persistent Odours last updated September 2015, includes an Odour Control Investigation Tool to identify the source of the lingering odour. The policy also indicates that all staff are to immediately report any unacceptable lingering odour to the Support Services Manager.

The Support Services Manager indicated during the same interview with Inspector #549 that staff are not following the procedure for managing lingering offensive odours. [s. 87. (2) (d)]

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 procedures are implemented to address lingering offensive odours, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions: i. the immediate actions that have been taken to prevent recurrence, and ii. the long term actions planned to correct the situation and prevent recurrence.

This finding is related to Log # 013864-15.

The home submitted a critical incident report on June 11, 2015 indicating the improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

The CIR indicates that resident #053's family member had reported to the RN that he/she suspected the bruising observed on specific body areas was sustained from improper transferring.

Section IV of the CIR detailing the analysis and follow-up that includes what immediate actions have been taken to prevent recurrence and what long term actions are planned to correct this situation and prevent recurrence, was not completed by the home.

During an interview with the DOC it was confirmed to Inspector #549 that CIR was not completed as required in writing with respect to making a report to the Director. [s. 104. (1) 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 the report to the Director included the analysis and follow-up actions i. the immediate actions that have been taken to prevent recurrence and ii. the long term actions planned to correct the situation and prevent recurrence., to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure as per O.Reg79/10, s.110 (7) that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

6. All assessment, reassessment and monitoring, including the resident's response.

Resident #032 is dependent on staff for activities of daily living and is identified as high risk for falls. The health care record was reviewed and resident #032 was assessed to require a seat belt while in a wheelchair. The POA consented and the physician ordered the seat belt on specified day in January, 2015.

On April 14, 2016 at approximately 1115 hours the resident #032 was observed to be in the wheelchair with the seat belt applied. The resident was not cognitively or physically

responsive to remove seat belt.

The home's process to document the effectiveness of the restraint and the resident’s response to the use of the physical device, seat belt, is to be completed on the document titled: Restraint Record by a registered practical nurses every eight hours.

On April 14, 2016 RPN #122 and RPN #139 both indicated the effectiveness of the restraint and the resident’s response is recorded once a shift on the Restraint Record. RPN #122 indicated the resident’s usual routine is to go to bed by 2100 hours.

The current care plan specifies to check the resident every hour when the restraints are utilized to ensure safety and to evaluate response.

The Restraint Record was reviewed for resident #032 for a specified period of time in April, 2016. From the documentation the restraint is removed during the evening the majority of time from 1900 hours to 2000 hours. During the period of time reviewed there is no record of the resident’s response or effectiveness of the physical device for each evening shift.

Resident’s # 076 and #077 Restraint Record and progress notes were reviewed for a specified period of time in April, 2016 in addition to the residents' current care plans. Both residents' care plan specifies the application of the seat belt while in the wheelchair.

For these two additional residents #076 and #077 the recorded time of removal of a physical device from the resident’s is at 1900 hours each evening. There is no documentation on the Restraint Record by registered practical nursing staff for each evening regarding the resident’s response to the seat belt and the effectiveness of the seat belt for the specified time in April, 2016.

On April 14, 2016 during an interview the DOC confirmed the expected assessment, reassessment and monitoring including the resident's response to the use of a physical device to restrain a resident is to be completed and recorded on the Restraint Record by registered practical nurses. [s. 110. (7) 6.]

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 documentation of all assessment, reassessment and monitoring including resident response with the use of a physical device to restrain a resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On April 6, 2016 on the 3rd floor in the presence of the DOC, inspector #548 observed a non-registered staff member exit the Medication room at approximately 12:50 hours.

On April 6, 2016 during an interview the supply support worker #118 indicated that she was in the medication room restocking. She indicated one of the registered nursing staff had unlocked the door for her to gain access to the room and that she was alone in the room while resupplying.

On April 6, 2016 during an interview RPN#103 indicated the key to the medication room is carried by registered nursing staff. RPN#103 indicated she opened the door to the medication room for the dietary support worker #118 to resupply and had initially stayed but, had not remained in the room with the non-registered staff member.

Inspector #548 observed both government stock and prescribed medications for residents to be stored in the medication room. [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 ensure access is to where all drugs are stored, to be implemented voluntarily.

WN #12: 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. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The Licensee has failed to ensure that each resident of the home receives

individualized personal care, including hygiene care and grooming on a daily basis.

On April 5, 2016 Inspector #548 observed resident #036 to have whitish long chin hairs.

The resident's #036 plan of care was reviewed. Resident #036 is totally dependent on staff to perform the tasks associated with personal hygiene.

The resident's current care plan intervention related to activity of daily living (ADLs) reads: Shower x 2 weekly. Have resident wash face and hands, staff to complete the rest.

On April 8, 2016 during an interview PSW #114 indicated that the resident tolerates the removal of hair by staff, which is completed on bath days. The resident is scheduled for bath days every Monday and Thursday of the week. The resident was scheduled to receive a bath during the day on April 11, 2016.

On April 13, 2016 Inspector #548 observed resident #036 to have a large amount of whitish hair to the chin line than previously observed.

On April 13, 2016 PSW #131 indicated that the resident resisted care and she was going to shave the resident later that morning.

On April 14, 2016 Inspector #548 observed resident #036 to be in the same groomed state as the day before.

On each occasion the Inspector #548 observed the resident to be calm and quiet.

On April 14, 2016 during an interview with inspector #548 PSW #131 indicated that while attempting to shave the resident the resident resisted care and the RPN #122 had been informed of the resident's behaviour.

On April 14, 2016 during an interview with inspector #548 RPN #122 indicated that she was not aware the resident resisted care as this was not typical for the resident.

At the home PSWs record the care provided and exhibited behaviours on a form titled PSW Daily Care Flow Sheets. Upon review of the flow sheets for specific dates in April,2016 for two weeks it is recorded the resident received the scheduled baths and the

resident was shaved once on a specific day in April, 2016.

The resident's plan of care does not specify resident grooming needs. [s. 32.]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that ensure resident drugs are stored in an area or medication cart that is secured and locked.

On April 4, 2015 inspector #549 observed during the morning medication pass on the 5th floor RPN #128 left the medication cart unlocked while in a resident's room. The resident's door was open and the registered practical nurse's back was to the cart across the hallway.

On April 4, 2016 on the 2nd floor inspector #138 was standing at the nursing station and heard a student yell "no". The medication cart was unsupervised and the inspector observed the resident to be sticking his finger in a medication cup with orange residue and lick his fingers. The student removed and disposed of the medication cup.

On April 5, 2016 at approximately 1130 hours on the 3rd floor inspector #548 observed a medication cart to be in the hallway, close to the elevators in the vicinity of a resident seating area, unlocked and unattended. There were one resident seated in the resident chairs several feet from the medication cart. The inspector stood by the cart for 2 minutes and the RPN #103 came out of the medication room and saw the inspector standing beside the cart. The RPN indicated that the cart should be locked and proceeded to do so.

On April 12, 2016 at 15:30 hours inspector #549 observed the medication cart parked on the 2nd floor secured unit by the housekeeping closet across from the nursing station to be unlocked and unattended. The RPN responsible for the medication cart was observed to be behind the chart rack at the nursing station out of view of the medication cart. Inspector #549 observed several residents around the medication cart at the time of the observation.

The home's policy Medication Carts, September 2010, policy #11-17 specifies the medication cart if not in use is to be kept locked. In addition, the policy indicated that when there are no registered nursing staff present there are to be no medication left on the top of the cart and the cart is to be locked.

On April 13, 2015 the ADOC confirmed it is expected that drugs are stored in an area or medication cart that is secured and locked. [s. 129. (1) (a)]

Issued on this 24th day of May, 2016

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

Original report signed by the inspector.