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

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Inspection de soins 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
Aug 5, 2016	2016_272641_0002	013469-16	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

FAIRVIEW LODGE
632 DUNDAS STREET WEST P.O. BOX 300 WHITBY ON L1N 5S3

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

CATHI KERR (641), ADAM CANN (634), CHARLES SMITH (635), LYNE DUCHESNE (117), MICHELLE JONES (655), NATALIE MOLIN (652), SUSAN SQUIRES (109), VERON ASH (535)

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): June 6 - 10, June 13 - 17, 2016

During this Resident Quality Inspection (RQI), two critical incident inspections were also conducted.

During the course of the inspection, the inspector(s) spoke with Administrator; Assistant Administrator; Director of Care, DOC; Two Resident Care Coordinators, RCC; Environmental Services Manager; Environmental Services Supervisor; Registered Dietitian, RD; Director of Food Services; Registered Nurses, RN; Registered Practical Nurses, RPN; Personal Support Workers, PSW; Dietary Aides; Maintainence Staff; Maintainence- Laundry Aides; Maintainence - Housekeeping Aides; Residents; Residents' Council President; Family Council Chairperson; Resident's Family members.

Inspectors also reviewed the following: several resident healthcare records; observed resident rooms and common areas; observed the evening meal service of June 6th and 13th; reviewed the minutes of the resident council and family council; reviewed the home's policies on prevention of abuse; falls management program; skin and wound program; the home's dietary program; the home's medication administration process; the home's infection prevention and control program;

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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)**
- **5 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

On a specified date, a resident sustained a fall resulting in an injury. A registered staff reported that a treatment was initiated for the injury.

Documentation and subsequent interviews with registered staff and the DOC revealed that the expected treatment monitoring and documentation was not completed as per policy and plan of care.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. A review of the licensee incidents notes revealed fall prevention strategies were not in place for a specified resident at risk for falls.

An interview with PSW #124 and RPN #141 revealed the fall prevention strategy was not engaged at the time the resident fell on a specified date. On another date, the resident was observed lying close to the edge of the bed and the fall prevention strategy was not engaged.

An Interview and observation with a PSW and a RPN, confirmed that the resident was lying at the edge of the bed and the fall prevention strategy was not engaged.

The Director of Care (DOC), confirmed that the staff should ensure the resident at risk for falls, had the prevention strategies identified in their plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care related to falls preventions and treatments are provided to residents, to be implemented voluntarily.

WN #2: 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 has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and locked when they are not being supervised by staff.

Observations were conducted on a specified date and the staff only room was found to be unlocked with no staff members present in the area which was accessible by residents. The door led to a hallway which had multiple rooms that were left unlocked within the corridor including a janitor room with multiple cleaning solutions accessible and a soiled utility room with accessible cleaning products.

An interview with Personal Support Worker (PSW) # 128 at the time the door was found unlocked, confirmed that the expectation was that the door should be locked.

The Administrator and the Assistant Administrator (AA) confirmed that the staff only area should be locked at all times. The AA reported that the home was having difficulty with the latch on the door and were addressing the concern.

Inspector #635 observed the Soiled cart room on Ashburn Way was unlocked. Personal Support Worker #162 (PSW), stated that the door should be locked, however advised that it would not lock. The PSW notified a maintenance worker who reprogrammed the lock on the door which was subsequently observed as locked on a daily basis.

Registered Nurse (RN) # 157 reported that the door should be kept locked and reported it to maintenance, who locked the door prior to the inspector leaving the floor.

An unlocked soiled cart was observed on Trafalgar Square.

The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and locked when they are not being supervised by staff. [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 that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents as it relates to the staff only room , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident be assessed and, if required, a post-fall assessment be conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A record review of the licensee incident reports and progress notes revealed a post fall assessment was not completed after a resident fell on a specified date.

RPN #138 confirmed a post fall assessment was not completed after the fall.
The DOC#147 and RCC#146 confirmed that a post fall assessment or huddle should be done when residents sustain a fall as per the Licensee's Fall Prevention Policy. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident be assessed and, if required, a post-fall assessment be conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident who depends on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance.

On a specified date, a resident was observed sitting in a chair leaning to the side of the chair, eating and drinking a small snack. Staff did not reposition the resident to a comfortable seating position.

On other specified dates, a resident was observed seated in a chair leaning to the side of the chair. Staff did not reposition the resident to a comfortable seating position.

PSW #159 and RPN #141, confirmed that the resident was leaning heavily to the side of the chair. PSW #159 was not aware of recommendations to reposition the resident upon certain indicators, back up in the wheelchair.

A review of the healthcare record, revealed that the OT had advised that the resident should be repositioned throughout the day, upon certain indicators. The nursing staff were aware and agreeable with the O.T.

RPN #141, confirmed that the OT's recommendation regarding the resident leaning to the side of the chair, was not identified in the resident's plan of care.

The Director of Care (DOC) and Resident Care Coordinator (RCC) confirmed that if a referral was sent to the OT and the OT made recommendations to address the resident's safe positioning, the staff should be following the recommendations. [s. 50. (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 that a resident, who is dependent on staff for repositioning, is repositioned every two hours or more frequently as required depending on the resident's condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participate in the implementation of the infection prevention and control program.

During a tour of Ashburn Way on a specified date, the following were observed: a fingernail file, a tube of barrier cream and a used hair brush were all unlabelled in a resident's communal washroom; an unlabelled drawer was found with a labelled nail clipper and nail clippings in one drawer of the plastic storage container in the spa room. In the same spa room, an unlabelled deodorant stick was found on the vanity near the toilet and another unlabelled deodorant stick was found beside the plastic storage bin.

During a tour of Cullen Gardens on a specified date, the following was observed: in the spa room, an unlabelled used comb was found on the vanity in the toileting area; an unlabelled used brush and deodorant stick were found on a shelf in the tub area of the spa room. In the hallway, green wash basins were found sitting on the hand rail; in the washroom in the hallway, a measuring hat was located on the vanity next to the sink.

During a tour of Trafalgar Square on a specified date, the following was observed: an unlabeled hair brush was found in the tub room on the shelf.

On a specified date, a bed pan and urine hat was observed on the floor beside the toilet in a shared washroom.

On a specified date during a medication pass, Registered Practical Nurse (RPN) #145, was observed to not wash or sanitize their hands after administering between residents

On specified dates, Food Service Aides and Personal Support Workers (PSW) did not wash or sanitize their hands between serving resident plates and handling dirty dishes.

Observations were conducted on a specified date. Food Services Aide #148 was observed plating the meat pot pies onto the resident plates with her bare hands.

Food Services Aide #148 said that the expectation of the home was that staff wash their hands before serving food and the staff member indicated that they would only touch food with their bare hands if their hands were clean. Food Services Aide #148 also indicated that they would only handle food directly while wearing gloves. Food Services Aide # 148 was not observed to be wearing gloves at the time of handling food directly.

Personal Support Worker #149 stated that the expectation of the home was that staff were to sanitize or wash their hands after touching anything dirty and before serving food plates to residents.

The Director of Care (DOC) #147 stated that the expectation of the home was that all resident's personal items were to be labeled, that staff wash their hands between residents when administering medications and that clean wash basins were to be stored in the cabinets located in the resident washrooms. [s. 229. (4)]

2. On a specified date, the following was observed: an unlabelled and unclean urinal on the top of the toilet tank, an unlabelled tube of barrier cream, and an unlabelled comb in a shared bathroom. Again on another specified date, the unlabelled urinal was observed sitting on the top of the toilet tank.

The Director of Care (DOC) #147, stated that the expectation of the home was that all resident personal care items were expected to be labelled and stored in the resident's bathroom cupboard. [s. 229. (4)]

3. On a specified date, the following was observed in a washroom, which was shared by two residents: a soiled pink unlabeled fracture pan on the floor next to the toilet.

PSW #155 confirm the fracture pan was soiled and should be cleaned, sanitized, labelled and placed in the appropriate resident's cupboard.

On a specified date, during a medication pass, RPN # 138 did not perform hand hygiene between residents. The RPN was also observed taking a capsule medication out of the package with their fingers. [s. 229. (4)]

4. During a tour of the home, the following infection control practice issues were observed: Whitby Junction home area had multiple communal supplies such as shaving cream and barrier cream, that were left in the home area Spa room; in the Yorkshire

Place home area a resident's soiled bed pan and urine collection measuring hat were left on the floor in the resident's shared washroom. In that same room, there were unlabelled personal items (tooth brush, shaving cream and a comb) that were observed in the semi-private room on the washroom counter.

On specified dates, direct care staff were observed serving the supper meal and lunch meal respectively for residents in the dining room. On both occasions, PSWs were interacting with multiple residents during the meal service without cleaning their hands between residents. During these same meal services, the registered staff on duty administered medication to multiple residents in the dining room without performing hand hygiene in between administering medications; and Dietary Aide #165 did not perform hand hygiene at any time during the meal service although she was out in the main dining room moving from one resident to another with the show plates, then she returned to the servery to continue to plate residents' meals.

An interview with the registered staff directed that the home's expectation was that all staff cleaned their hands between serving and providing care to residents. Further, the Director of Care #147 and Resident Care Coordinator #146 identified that the expectation of the home was that all resident's personal items were to be labeled, that staff wash their hands between residents when administering medications and that clean wash basins were to be stored in the cabinets located in the resident washrooms. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all resident's personal items are labelled with the resident's name and that clean wash basins are placed in the resident's cabinets . Further, that staff wash their hands between residents when administering medications and when serving residents in the dining room, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be afforded privacy in treatment in caring for his or her personal needs.

On a specified date, Registered Practical Nurse (RPN) #145 administered a specific medication to a resident who was seated at the table in the dining room with other residents present. A record review of the current plan of care for the resident showed that there was no plan indicating that the resident was to be administered this medication while in the dining room.

The Director of Care #147 and Resident Care Coordinator #146 stated that medications were not to be administered to a resident while a resident was in the dining room unless indicated in a resident's care plan. [s. 3. (1) 8.]

2. Registered Practical Nurse (RPN) #134 administered a medication to specific resident who was sitting in a chair in an open corridor of the resident home area without offering privacy. The Director of Care #147 and Resident Care Coordinator #146 stated that staff were expected to provide privacy when medication and other treatments were administered to a resident unless indicated in a resident's plan of care.

Record review of the current plan of care for the resident showed that there was no plan to administer the medication to the resident without affording privacy. [s. 3. (1) 8.]

WN #7: 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, furnishings and equipment are kept clean and sanitary.

On a specified date, two resident's observed to have unclean walkers.
The walker of one resident was observed to be unclean with white dust, and white flaky debris on the walker seat, on several specified dates.

On a specified date, the family members of one of the residents stated that they had cleaned the walker themselves approximately one month prior. They do not believe the walker had been cleaned since.

The walker of another resident was observed to be unclean with a linear strip of white sticky adhesive material on several specified dates. The tray of a specific resident was also observed to be unclean on two specified dates.
RPN #101, indicated that maintenance staff was responsible for cleaning resident equipment such as walkers and wheelchairs, on the night shift. She also stated that unit staff may clean the equipment if it was observed to be unclean, or they would report the unclean equipment to maintenance for cleaning.

PSW #132, indicated there was no known documentation that would track the cleaning of any one specific piece of equipment. PSW #132 was shown the unclean walker and acknowledged that the walker needed to be cleaned.

Maintenance worker #118, acknowledged that there was no mechanism in place to indicate when each specific piece of equipment was cleaned. The Environmental Services Manager #102 stated that maintenance was responsible for cleaning all

resident equipment routinely on night shift. He also stated that nursing would notify maintenance if the equipment was observed to be unclean, or that the unit staff would clean it on the unit themselves. Environmental Services Manager #102 provided copies of the Wheelchair Cleaning Schedule, and OPER-06-01-01, Policy Title: housekeeping. He acknowledged that there was no way to determine which individual piece of resident equipment was cleaned or when. [s. 15. (2) (a)]

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

On a specified date, the inspector observed that one toilet grab bar was loose on the left side while standing directly in front of the toilet, in a communal washroom.

The inspector observed on another specified date, that the left grab bar was loose as it moved from side to side compared to the secured grab bar on the right side when standing directly in front of the toilet. The right grab bar properly locked in position when pushed downwards and the left grab bar moved when it was pushed downwards into the locked position .

Personal Support Worker (PSW) #109 stated that the expectation of the home was that the grab bars in the resident washrooms were secure. PSW #109 stated that if a loose grab bar was found it would be reported to maintenance and inputted into the blue maintenance book.

Environmental Supervisor #110 stated that staff were to fill out a maintenance requisition form in the blue maintenance binder if concerns were identified and that there was a maintenance staff member on each floor who checked the blue maintenance binder twice daily. Environment Supervisor #110 confirmed that the left grab bar was loose and that they were going to write it in the blue maintenance binder for the communal washroom.

On a further specified date, the inspector observed that the left grab bar had not been repaired as it was still physically loose.

Environmental Supervisor #110, stated that they spoke with the Environmental Manager #102 who confirmed that the home does not have a preventative maintenance program particularly for grab bars and that the process was for staff members to identify concerns and write the concerns in the blue maintenance book. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that O.Reg.79.10 sec 17(1)(a) as it relates to the home having a resident-staff communication response system, such as a call bell, that can be easily seen, accessed, and used by residents, staff and visitors at all times.

On a specified date, a specific resident's call bell was observed to be on the floor behind the bed. The call bell activation button was not accessible.

On further specified dates, the resident's call bell was on the floor beside the bed. The resident was laying on the bed, with the call bell out of reach on the floor.

The resident's current plan of care notes that the resident's call bell was to be accessible at all times. The daily care flow sheets documents that the resident's call bell was working and within reach on each shift.
PSW #128 stated that call bells should be clipped to the resident when they were in bed.

RN, #157, stated that all residents should have a call bell within reach when they were in bed. RN #157 observed the specific resident's call bell clipped to the resident's pillow case, with a large portion of the cord draped over the headboard, with the call button on the floor behind the bed. RN, #157 stated that this wasn't acceptable.

The DOC stated that it was the responsibility of all staff to ensure that the call bells were accessible and within residents' reach. She further added that when the PSWs entered and exited a resident's room, they were responsible to ensure that the bell was within reach of the resident each time and that the call bell accessibility is addressed in all resident care plans. [s. 17. (1) (a)]

2. On a specified date, a resident's call bell was on the floor next to the bed. On another specified date, the resident's call bell was again noted to be in the same position on the floor beside the bed.

PSW #142, stated that it was the responsibility of all staff to ensure that call bells were accessible to the residents. The Director of Care #147, indicated that it was the responsibility of all staff to ensure that the call bells were accessible and within the resident's reach. The DOC added that when the PSWs were entering and exiting the rooms, they were responsible to ensure that the bells were within reach each time. The DOC further stated that if a resident was not capable of using the call bell device, this would be care planned for, explaining that there were alternative devices available. When an alternative call bell device was used, it would be noted in the residents' care plans. The resident's care plan stated that the call bell was to be within reach. The DOC stated that to her knowledge, the resident was not identified as a resident who was in need of an alternate call bell device. [s. 17. (1) (a)]

3. On an specified date, the call bell in a resident's washroom was located on the wall behind the toilet and was not accessible to the resident. The Director of Care #147 stated that it was her expectation that staff ensure the call bell in the residents' bedrooms and washrooms were accessible to residents at all times. [s. 17. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff uses all equipment in the home, in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23

On a specified date, the ceiling lift bars in a communal washroom was observed to be approximately two feet above the toilet. Hanging bars over the toilet presented a safety risk for hitting the resident's head. The home's written Minimal Lift Program document, dated March 2014, indicated that "once procedure is completed, ceiling lift must be returned to charger (docking station).

On another specified date, the ceiling lift bars in a communal washroom was observed to be approximately two feet directly above the toilet. Personal Support Worker (PSW) #111 stated that the expectation of the home was that the ceiling lifts in resident washrooms were to be raised to the highest position possible after use. PSW #111 confirmed that the height of the ceiling lift in the washroom in a resident room was too low. PSW #111 confirmed that the resident who uses the washroom could potentially hit their head.

On a specified date, the ceiling lift in a specified washroom was in a position approximately two feet directly above the toilet. There was a sign posted on the wall above the toilet which read that the lift must be raised to the highest position after use.

Maintenance/ Housekeeper #150 confirmed that nursing was responsible for ensuring that the ceiling lift was raised to a safe height where residents cannot hit their head. Maintenance/ Housekeeper #150 identified that if they were to see a ceiling lift at an unsafe height, they would raise it to the proper safe height.

The Waverley Glen lift model # C450/C625 Owner's Manual (rev 6/23/2008) was supplied by the AA. The above manual stated on page 13, "The lift can now be moved to a safe location until further use… It is recommended that the lift be left on charge when not in operation." On page 14, under "Charging the lift", it was stated that – "It is recommended that the lift be left on charge when not in operation, and at the end of each day." It was further stated that -"As a general rule it is recommended that the carry bar be raised to a height so that it will not interfere with anything or anyone."

The Director of Care and the Resident Care Coordinator #146, confirmed that ceiling lifts are to be raised to a safe position where an individual would not be able to hit their head. [s. 23.]

WN #10: 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 a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

On a specified date a specific resident was observed to have an injury.

Personal Support Worker (PSW) #133 reported that when a resident had a bath, the PSW's completed an assessment of the resident's skin and documented on the Personal Support Worker Skin Observation Tool if the resident had any altered skin integrity. If altered skin was identified, the PSW would report this to the Registered Practical Nurse (RPN) and make a note on the 24 hour report sheet.

A review of the Personal Support Worker Skin Observation Tool indicated that there were only two entries made during a specified period for this specific resident.

RPN #134 reported that when the PSWs were bathing residents, they were to observe the condition of the resident's skin. RPN #134 reported that she had directed the PSW's to only document on the Personal Support Worker Skin Observation Tool if they discovered altered skin integrity. RPN #134 was unaware of any recent injury on the specific resident.

RCC #146 and #129 stated that the expectation was for the PSWs to document on the Personal Support Worker Skin Observation Tool when providing a bath for each resident. RCC #129 stated that the direction provided by RPN #134 was not the expectation of the home and that documentation on the tool was to be completed each time even if the resident's skin was not altered.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, were documented. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is dressed in accordance with their preferences.

A resident was observed to be dressed in inappropriate clothing. The resident was assessed and as a result of that assessment, the resident was required to wear specific clothing. The resident was feeling less dignified with the clothing. The resident stated they felt ashamed of the way they were dressed. The PSW told the inspector that the resident had told her that they were unhappy with the clothing.

The DOC told the inspector that it was her expectation that the staff respect the residents rights and involve them in their care decisions. [s. 40.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) 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; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or 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, that the plan, policy, protocol, procedure, strategy or system, is complied with.

The Home's medication policy addressing discontinuation, removal and destruction of a

controlled substance was not followed. A discontinued controlled medication was found in the medication cart double locked storage area, not separated from medications available for administration to residents.

A medication was discontinued by physician order on a specified date. Completion of the Narcotics / controlled substances storage count showed the presence of the medication in the medication cart double locked storage area and ongoing counting of this medication during the shift count process, against the narcotic/controlled drug record after this date.

The specific resident's chart showed that there were no current orders for this medication.

A review of the Home's medication policy, #5-4, Drug Destruction and Disposal, dated January 2014, showed that, all medications which become surplus due to expiry, illegible labels, discontinuation, change in order, resident death or discharge, are destroyed and disposed of, according to applicable legislation.

The procedure related to drug destruction and disposal of monitored medications described:
8. The nurse who processes an order to discontinue a monitored medication or processes a monitored medication requiring disposal, is responsible for removing the medication(s) from the medication cart double locked storage area during the shift count.
14. Retain the medications in a double-locked area within the home, separate from those medications available for administration to a resident.

The Director of Care (DOC) #147, Resident Care Coordinator (RCC) , #146, and RCC #129, acknowledged that the Home's policy relating to drug destruction and disposal had not been followed and stated that the expectation was that staff would comply with the required policy.

The licensee has failed to ensure that where the Act or 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, is complied with. [s. 114. (3) (a)]

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 drugs are stored in an area or a medication cart that is secured and locked.

On a specified date, Registered Practical Nurse (RPN) #145 left their medication cart unlocked in the hallway while administering medications to a resident.

RPN #145 stated that the expectation of the home was that medication carts were to be locked anytime they were unattended. RPN #145 confirmed that they left their medication cart unlocked upon entering into a resident's room. At another specified time, RPN #145 left their medication cart unlocked in the hallway while they were in another resident's room.

The Director of Care (DOC) #147 stated that the expectation of the home was that all medication carts were to be locked when staff were an arm's length away from the cart or could not see the cart. [s. 129. (1) (a)]

Issued on this 8th day of August, 2016

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

Original report signed by the inspector.