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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 15, 2015	2014_297558_0023	T-029-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

FUDGER HOUSE
439 SHERBOURNE STREET TORONTO ON M4X 1K6

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

BARBARA PARISOTTO (558), JULIET MANDERSON-GRAY (607), SARAH KENNEDY (605)

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): December 30, 31, 2014, January 2, 5, 6, 7, 8, 9, 12, 2015.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant administrator (AA), director of care (DOC), 1 west nurse manager (1W NM), 2 east nurse manager (2E NM), 3 east nurse manager/infection prevention and control nurse manager (3E NM/IPAC NM), 3 west nurse manager (3W NM), manager resident services (MRS),nutrition manager (NM), registered dietitian (RD), registered nurse (RN), registered practical nurse (RPN), recreation services assistant (RSA), complimentary care assistant (CCA), personal care aides (PCA), dietary aides (DA), handy man, housekeepers, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **6 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 failed to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Staff interviews revealed resident #05 experienced a decrease in participation in recreation activities over the past six months related to a change in medical condition. A record review revealed resident #05 participates in activities one third of the time and is

bedfast most of the time.

A review of resident #05's November and December 2014 activity attendance sheets indicated that the resident received alternate therapies in addition to recreation activities. An interview with the RSA revealed she was uncertain whether resident #05 was receiving alternate therapies as the resident's plan of care did not indicate such.

An interview with the CCA revealed an awareness of resident #05's decrease in participation in activities, increase of time in bed and revealed resident #05 would be a candidate for the CCA's case load. The CCA explained the case load is built from written referrals generated by the multidisciplinary team. The CCA had not received a referral for resident #05 and therefore resident #05 was not assessed and was not receiving alternate therapies. [s. 6. (4) (a)]

2. 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.

An interview with resident #02 revealed that the resident receives mouth care in the morning. A record review of the nursing and personal care record for January 2015, indicated resident #02's mouth care was provided each morning.

The resident's quarterly assessment dated December 8, 2014, revealed the resident resists care daily over the past 7 days. The care plan printed on December 23, 2014, stated: staff provide mouth care in the morning, after each meal and HS (bed time).

An interview with registered staff confirmed that the resident should be offered mouth care as per the plan of care despite frequent refusals by the resident of daily care.

An interview with a PCA revealed a lack of awareness of the care set out in the plan of care related to mouth care and confirmed care is not provided as specified in the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the plan of care and given convenient and immediate access to it.

A review of the care plan binder could not locate the nutrition care plan for resident #03. Interviews with two PCAs confirmed that they reference the care plan binder to determine

the care requirements of the residents.

An interview with a registered staff member confirmed that the nutrition care plan should be printed by the registered dietitian and kept in the care plan binder for staff to access. [s. 6. (8)]

4. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

The care plan for resident #02 dated December 8, 2014, stated: staff provide mouth care in the morning, after each meal and HS (bed time). The resident's quarterly assessment dated December 8, 2014, revealed the resident resisted care daily over the past 7 days.

A record review of the nursing and personal care record for January 2015, revealed resident #02's mouth care was provided each morning from January 1-7, 2015. The record did not indicate whether care was provided or whether the resident refused care at alternate times of day. A review of the evening shift assignment sheet did not indicate the provision or refusal of mouth care from January 1-7, 2015.

Staff interviews confirmed that the provision or refusal of care is to be documented on the nursing and personal care record. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan of care is no longer necessary.

A review of resident #12's plan of care revealed that the resident has an acute, reversible visual function problem and there is potential for visual function improvement if resident uses the provided corrective devices. Staff is to ensure that eyeglasses are being worn by resident and that eyeglasses fit correctly.

Interviews with two identified PCAs confirmed that the resident is not wearing eyeglasses because he/she takes them off and throws them.

Interview with registered nursing staff confirmed that the resident has eyeglasses but is not using them at the present time and that the plan of care should be revised to reflect the resident's current condition. [s. 6. (10) (b)]

6. On January 6, 2015, at 1:22 p.m. the inspector observed resident #03 being served fluids of regular consistency. A review of the resident's written care plan, physician's order and servery diet list revealed that resident #03 should be provided with nectar thick fluids related to oral/pharyngeal swallowing difficulties.

Interview with the RD confirmed that resident #03 should be receiving fluids of regular consistency and not nectar thick fluids as per the plan of care.

The plan of care was not revised when resident #03's fluid consistency changed. [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 that
- staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- the care set out in the plan of care is provided to the resident as specified in the plan,
- the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan of care is no longer necessary, 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are:

i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be canceled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

During the course of the inspection commenced on December 30, 2014, two doors from the basement leading into stairways and accessible by residents, were observed to be unlocked, not equipped with a door access control system, and are not equipped with an audible door alarm.

Interviews with the handy man, the AA and the administrator confirmed that the home's expectation is that all doors leading to stairways must be kept locked and secure. [s. 9. (1)]

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

On December 30, 2014, the hair dressing lounge and the telephone room, both located in the basement and accessible to residents, were found with unlocked doors and not being supervised by staff.

An interview with the handy man, AA and the administrator confirmed that the identified doors must be kept locked. [s. 9. (1) 2.]

3. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

An interview with the AA and the administrator confirmed that the home does not have a written policy that deals with doors that should be locked, unlocked or to doors leading to secure outside areas, stairways and doors that permit or restrict unsupervised access to areas by residents. [s. 9. (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 stairways are kept closed and locked, and equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be canceled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door,
- 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,
- there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

a.) On December 30, 2014, and January 6, 2015, the following was observed to be dirty:

- ceiling fan in the 3 east shower room,
- a sprinkler head in the 1 west shower room and
- two stained shower chairs in the 3 east and west shower rooms.

Staff interviews confirmed it is the housekeeper's role to complete high dusting and a housekeeper confirmed the ceiling fan was dirty.

Interviews with a PCA and IPAC NM confirmed the shower chairs were in poor and unsafe condition and are unsanitary.

The housekeeper was later seen proceeding to clean the ceiling fan with a vacuum. On January 12, 2015, the AA identified that the shower chairs would be replaced with new ones.

b.) On December 30, 2014, and January 6, 2015, resident #12's wheelchair and the walkers of residents #02 and #11 were observed to be stained and dirty. Staff interviews confirmed housekeeping is responsible for scheduled cleaning of ambulation equipment and that nursing staff may contact housekeeping if a piece of equipment required immediate attention.

A record review and interview with a housekeeper responsible for cleaning ambulation equipment confirmed that resident #02, #11 and #12's ambulation equipment was dirty. The housekeeper stated resident #12's wheelchair had not been cleaned since admission and identified resident #02's walker was last cleaned in October or November 2014. [s. 15. (2) (a)]

Additional Required Actions:

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

WN #4: 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 and interventions are documented.

On January 6, 2015, at 1:22 p.m. the inspector observed resident #03 being served fluids of regular consistency. A review of the resident's written care plan, physician's order and servery diet list revealed that resident #03 should be provided with nectar thick fluids related to oral/pharyngeal swallowing difficulties.

Interview with the RD revealed that resident #03 should be receiving regular consistency fluids as per the most recent assessment. The RD confirmed that this reassessment was not documented. [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 that any actions taken with respect to a resident under a program, including assessments, reassessments and interventions are documented, to be implemented voluntarily.

WN #5: 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 locked at all times, when not in use.

On December 30, 2014, at 10:30 a.m. medication room #3W-14 was observed to be unlocked with the medication cart in the room.
An interview with the registered staff member confirmed that the medication door should be locked at all times.
An interview with the DOC confirmed that the home's expectation is that the medication room is a secured area and should be locked at all times. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all areas where drugs are stored are locked at all times, when not in use, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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 a written record of the annual Infection Prevention and Control program evaluation includes a summary of the changes made and the date those changes were implemented.

A review of the annual program evaluation for Infection Prevention and Control completed on August 15, 2014, identified three changes/process improvements implemented and did not include a record of the date those changes were implemented. [s. 229. (2) (e)]

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

a.) On January 6, 2015, at 12:45 p.m. during the medication administration for resident #16 the inspector observed the registered staff did not perform hand hygiene before or after administering the medication to resident #16 and proceeded to administer medications to another resident.

An interview with the staff member confirmed hands should be cleaned before and after administering medications.

b.) On December 31, 2014, at 10:45 a.m. observation revealed an unlabeled comb and toothbrush in a shared washroom on 2E and an unlabeled toothbrush, toothpaste and emesis basin in a shared washroom on 2E.
An interview with a PCA and a registered staff member confirmed that the personal items should be labeled.

An interview with the IPAC NM confirmed that personal care items should be labeled and unlabeled items present a risk for infection. [s. 229. (4)

3. On December 31, 2014, two bedside call bells, one on 1W and one on 1E was observed to be on the floor. On January 2 and 9, 2015, a bedside call bell on 1W was observed touching the floor.

An interview with the IPAC NM confirmed that the call bell should not be on the floor and that this presents a risk for infection. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

A record review indicated that four identified concerns directed to the building services department were raised during the September 22, 2014, Residents' Council meeting. The Residents' Council assistant received three written responses to the concerns on October 9, 2014, and one response on October 20, 2014.
An interview with the AA confirmed that written responses were not provided to these concerns within the designated 10 day time frame. [s. 57. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who is a member of staff of the home is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Interview with the RD revealed that the RD works at the home for 112 hours per month and is the sole dietitian in the home. The RD confirmed there are 249 residents in the home and that there is an expectation that the registered dietitian be at the home for a minimum of 30 minutes per resident per month. The RD confirmed that the registered dietitian should be spending 124.5 hours in the home every month. [s. 74. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council is sought in developing and carrying out the satisfaction survey.

An interview with the Residents' Council assistant revealed that the home uses a standardized survey developed by the corporate head office, and residents are therefore not consulted in developing and carrying out the home's annual satisfaction survey.

An interview with the administrator confirmed that the home uses a standardized satisfaction survey and Residents' Council was not consulted in the development or carrying out of the satisfaction survey since 2012. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey.

An interview with the Family Council assistant revealed that the home uses a standardized survey developed by the corporate head office, and Family Council are therefore not consulted in developing and carrying out the home's annual satisfaction survey.

An interview with the administrator confirmed that the home uses a standardized satisfaction survey and Family Council was not consulted in the development or carrying out of the satisfaction survey since 2012. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances are labeled properly and kept inaccessible to residents at all times.

On December 30, 2014, a door marked "kitchen" in the basement was unlocked and a bottle with Windex was noted sitting on the floor with the label “contents harmful, do not swallow”. This home area is accessible to residents.

An interview with the handyman confirmed that the chemical was Windex and should not have been stored in the area and removed it.
An interview with the AA confirmed that the door should be locked and the chemicals should not have been left unattended in the kitchen area. [s. 91.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of a home has been investigated, resolved where possible and a response provided within 10 business days of the complaint.

Interview with resident #07 revealed that he/she verbally reported to a registered staff member that the watch went missing approximately 6 months ago. The resident stated the watch was never found and staff did not follow-up within 10 days of the complaint.

A review of resident #07's chart and the complaint systems management log revealed that this incident was not documented.

Interview with the DOC revealed that the expectation is for staff to report missing items to the charge nurse. A concern form needs to be completed if an item is not located within an acceptable time frame and management needs to follow-up with the resident. The DOC was unsure whether staff understand this process. [s. 101. (1) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented.

A review of the home's annual medication management system evaluation dated October 8, 2014, demonstrated what resources were used to evaluate the program but did not include a written record of any changes that were implemented.

An interview with the DOC confirmed that the home is currently evaluating the medication program but is not keeping a record of the changes that were implemented. [s. 116. (5)]

Issued on this 15th day of January, 2015

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

Original report signed by the inspector.