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 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
Dec 13, 2016	2016_293554_0024	031075-16	Resident Quality Inspection

Licensee/Titulaire de permis

KNOLLCREST LODGE LIMITED
50 William Street, Milveton PERTH ON N0K 1M0

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

KNOLLCREST LODGE
50 WILLIAM STREET MILVERTON ON N0K 1M0

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

KELLY BURNS (554), PATRICIA MATA (571)

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): November 21, to November 25, 2016

Resident Quality Inspection (RQI), Intake 031075-16 ; also during this RQI, the inspectors reviewed and inspected concurrent intakes 024987-15, 018204-16, and 021905-16.

Summary of Intakes, inspected concurrently:

1) 02498-15 - Follow Up to Inspection 2015_271532_0021, Compliance Order (CO 001) related to O. Reg. 79 10, s. 50 (2), compliance due by October 30, 2015.
2) 018204-16 - Critical Incident Report - Incident that occurs to a resident resulting in injury to the resident; resident is taken to hospital and such results in a significant change in the resident's health condition.
3) 021905-16 - Critical Incident Report - Incident that occurs to a resident resulting in injury to the resident; resident is taken to hospital and such results in a significant change in the resident's health condition.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Resident Care (DRC), Activity Lead Hand, Quality Nurse-Staff Education and RAI-C, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Housekeeping Aid, Dietary Aid, Physio-Therapy Assistant, Maintenance Staff, Nurse Practitioner, Physician, Pharmacy Consultant (s), President of Resident Council, Families, and Residents.

During the course of the inspection, the inspector(s), toured the long-term care home, observed staff to resident interactions, observed resident to resident interactions, reviewed clinical health records, reviewed meeting minutes of the Resident Council, Family Meetings, Agenda for LTC Homes Training (2015), annual staff retraining statistics for 2015 and 2016, maintenance repairs request binder, reviewed home specific policies (Medication Pass, Expiry Date Policy, Eye Ointment and Drops, Nasal Sprays, Prescribed Topical Treatment Creams, Self-Administration of Medications: Residents, Consent for Unsupervised Self-Administration of Prescribed Drugs, Falls Prevention and Management-Falling Star Program, Falls Assessment and Incident Report, Falls Risk Assessment, Overview-Resident Handling, Sit Stand Lifts Sara 3000, Mobility Assessments, Handwashing, Skin and Wound Care Policy, and Prevention of Abuse and Neglect).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Training and Orientation

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2015_271532_0021	571

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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specific to falls prevention and management.

Related to Intake 021905-16, for Resident #027:

Resident #027 has a history which includes cognitive impairment. According to the clinical health record (written care plan, and risk assessments), resident #027 is a risk for falls.

Registered Practical Nurse (RPN) #101 and Personal Support Worker (PSW) #108 both indicated that resident remains at risk for falls and interventions include, bed and chair alarms to be on whenever resident is in his/her mobility chair, (or in bed).

The clinical health record (last revised on a specific date) provides the following direction in the care of resident #027:

- Falls Risk, related to history, unsteady gait, and impaired balance; interventions include (but not limited to) have an chair alarm on mobility chair.

On an identified date, resident #027 was observed in his/her mobility chair with a chair alarm attached, the chair's alarm was observed to be off during this observation.

Personal Support Worker #108 confirmed that the chair alarm was off at the time. Personal Support Worker indicated the chair alarm should have been turned on.

Registered Nurse #100, as well as the Director of Resident Care, indicated (to the inspector) there have been issues with staff not turning on chair (and or bed) alarms, or alarms not consistently working. [s. 6. (7)]

2. Related to Resident #005:

Resident #005 has a history which includes cognitive impairment. Resident #005 is dependent on staff for all activities of daily living.

The plan of care (last revised on a specific date) details the following:
- Falls Risk, due to cognitive impairment and impaired balance; and
- two safety devices to be up while resident is in bed; maintain bed at low height once care provided.

On three identified dates, resident #005 was observed (by the inspector) lying in bed. Resident #005's hi-low bed was in the highest position, with the two safety devices

engaged.

Personal Support Worker (PSW) #108 indicated (to the inspector) hi-low beds are to be in the lowest position whenever a resident is in the bed. PSW #108 indicated, it was his/her belief that resident #005 is no longer a falls risk. PSW #108 indicated, we often leave resident #005's bed in the highest position, as it is easier for staff.

Registered Practical Nurse (RPN) #101 indicated, resident #005 is considered at risk for falls. RPN #101 indicated (to the inspector), an intervention for those, residents, at risk for falls would be the hi-low bed. RPN #108 indicated, resident #005 is considered at risk for falls.

Director of Resident Care (DRC) indicated if a resident is in a hi-low bed, they have been assessed to be at risk for falls. Hi-low beds are at all times to be in the lowest position if a resident is lying in the bed. [s. 6. (7)]

3. Related to Resident #001:

Resident #001 has a history which includes physical and cognitive impairment.

The plan of care (for two identified dates) directed the following:
- Resident #001 is dependent on staff for activities of daily living; utilizes two staff with mechanical transfer device for all transfers. Uses mobility aide for mobility;
- Is at risk for falls, related to history, and cognitive and physical impairments;
- Uses a touch sensitive call bed while in bed; ensure it is positioned within reach or where resident will roll onto it if attempting to crawl out of bed;
- Bed alarm on bed; ensure alarm is turned on while resident is in bed; respond immediately to alarm;
- an identified safety device with chair alarm to be used when resident is in chair, as a cue not to self-ambulate.

The clinical health records, specifically the progress notes, were reviewed (by the inspector) for the period of approximately eight months; progress notes reviewed detailed two specific fall incidents:

- On an identified date and time – Resident #001 was found on the floor by a personal support worker. Personal Support Worker indicated resident #001 had been left to sleep in his/her chair; staff returned to find him/her on the floor. Resident #001's chair alarm

was not turned on. Post fall, resident #001 complained of discomfort.

- On an identified date and time – Resident #001 was found lying on the floor beside his/her bed. Resident #001's bed alarm was not on. Resident #001 did not sustain injury as per the progress notes.

Director of Resident Care reviewed the Post Falls Incidents (with the inspector) confirming that the bed and or chair alarms, identified in the plan of care, for resident #001, were not in use during two identified dates, when resident #001 fell.

Registered Nurse #100, as well as the Director of Resident Care, indicated (to the inspector) there have been issues with staff not turning on chair (and or bed) alarms, or alarms consistently working.

Director of Resident Care indicated that she is currently in the process of trialing alternative chair (and or bed) alarms. [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 there is a process in place and monitored, ensuring that the care set out in the plan of care is provided to the resident(s) as specified in the plan, specific to falls prevention and management, 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to medication management systems.

Under O. Reg. 79/10, s. 114 (1) - Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Under O. Reg. 79/10, s. 114 (2) - The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's policy, Expiry Date Policy directs the following:

- PRN (as needed) meds dispensed in a blister pack are filled with a one week supply, with at least six month expiration life or longer. When the card is in circulation longer than six months, nursing will call pharmacy to confirm expiry date;
- Diligence is required by the registered (nursing) staff in checking dates on PRN medications;
- Meds stored in unit med rooms will be audited for expiration dates routinely by registered (nursing) staff.

On an identified date, the following was observed (by an inspector):

- Four separate blister packages of identified prescribed PRN medications, belonging to

residents #004, #050, #051 and #052, were visualized by the inspector, the medication blister packages observed did not have an expiration date identified on the said packages.

Registered Practical Nurse (RPN) #101, who was administering medications during this inspection confirmed, with the inspector, that there was no expiration dates on the medication blister packages for resident #004, #050, #051 and or #052. RPN #101 indicated (to the inspector) being unsure how to check for expiry dates on medication blister packs.

Pharmacy Consultant indicated, to the inspector, on an identified date, that the pharmacy relies on registered nursing staff to contact them, regarding expiration dates; the pharmacy does not place expiration dates on PRN blister card packages. If a medication, in a blister package has a packaging date of six months or greater, then registered nursing staff should be contacting us to inquire as to expiration. Pharmacy Consultant indicated there is no record of the registered nursing staff contacting us, as to expiration dates.

Director of Resident Care indicated, no awareness of PRN blister packaging not having expiration dates. Director of Resident Care commented that there were no documented records to support that registered nursing staff were completed the expiration date audits as per the home's policy and/or procedure. [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 there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically as such relates to medication management systems, 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).

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

During this inspection, the door to a utility/hopper room was observed unlocked and having no staff in attendance. Within this utility/hopper room was an opened bottle of "Enhance" which is a neutralizing all-purpose cleanser, sitting on the floor. The utility/hopper room is located on an identified resident home area.

The same room was found unlocked, for a second time, during the same day.

During both observations, residents were observed walking past the room or sitting in wheelchairs within the rooms vicinity.

The CEO indicated (to the inspector) that the utility/hopper room was not to be left unlocked. CEO took her keys, locked the door to the room. CEO indicated the utility/hopper room is a non-residential area. [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, equipped with locks to restrict unsupervised access to those areas by residents, and are 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, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During dates of this inspection areas within the home were observed to be dimly lit, as some of the lights within resident accessible common areas (lounges and dining rooms) and hallways were either off and or not functioning.

Interior lights within the long-term care home determined by the inspector to be not working when the light receptacles were turned on, are as follows:

- Ceiling Lights (centre ceiling lighting, large rectangle fluorescent) – there was twelve lights not functioning; these lights were located in the hallways within the resident home areas, the large activity room and in the main foyer;

- Pot Lights - there was twenty-one lights not functioning; these lights were located within the hallways of both, resident home areas, inside one of the main dining room, outside of the communal washrooms on one identified resident home area, and in an identified lounge.

The Maintenance Staff indicated (to the inspector) not being aware that the lights identified were not working. During this same discussion, the maintenance staff indicated that he would check the lights to see if light bulbs were burnt out or turned off. During a secondary interview, the maintenance staff indicated that the some of the lights in the long-term care home were not working. Maintenance Staff further indicated that some of the identified lights had burnt out light bulbs and others had a malfunctioning ballast(s) which needed repair. Maintenance Staff indicated not having any replacement bulbs on site in the long-term care home, and would have to order some replacement bulbs in.

The CEO, who oversees the operations of the maintenance department, indicated that the long-term care home normally keeps some lights in the long-term care home turned off, in an effort to conserve energy. During a second interview (the same day), CEO indicated no awareness of the number of light bulbs being burnt out or not functioning in the long-term care home.

During observations, during this inspection, the secured courtyard was observed in disrepair, as follows:
- Concrete patio slabs along the walk-way, within the courtyard were observed uneven, and cracked in areas.
- A hole, measuring approximately twenty feet long by eight feet wide, and a foot depth was visible within the centre of the courtyard's grassed area.

Activity Lead indicated (to the inspector) residents were not able to use the courtyard due to the disrepair of the courtyard. Activity Lead indicated there is no place for residents with cognitive impairments or those that wander to go outside.

Resident Council Meeting Minutes (reviewed for a period of eleven months), as well as the 2016 Family Meeting Minutes, confirmed that residents and families have voiced concerns, during their meetings, as to the inability of residents to use or enjoy the courtyard due to its disrepair.

CEO, who oversees the operations of the long-term care home, including the maintenance department, confirmed (with the inspector) that the hole in the courtyard

had been there four to five years. CEO indicated (to the inspector) that there is currently no plans in place to repair the courtyard. [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 there is a process in place and monitored, ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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 there is a resident-staff communication and response system available in every area accessible by residents.

During this inspection, it was observed that two resident accessible areas did not have a resident-staff communication and response system available. These areas were identified as the family room and the greenhouse.

On an identified date during this inspection, it was further observed that there was no resident-staff communication and response system in the patio area, located at the front of the long-term care home, this is also considered the resident smoking area.

This was brought to the CEO`s attention the same day. The CEO indicated that call bells are being installed to the indicated areas as of a stated date.

Therefore, the licensee failed to ensure a resident-staff communication and response system is available in every area accessible by residents. [s. 17. (1) (e)]

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 there is a resident-staff communication and response system available in every area accessible by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

The home's policy, Sit Stand Lifts Sara 3000 directs that the sit stand lift is used for lifting

and transporting a resident. The lift is to be used for purpose described only. Improper use can result in injury to the resident.

Related to Intake #021905-16, for resident #027:

Resident #027 has a history which includes cognitive impairment. Resident #027 is at risk for falls.

The clinical health record (reviewed for two specific dates) provides details of the following:
- Resident #027 is dependent on staff for activities of daily living; and
- requires the use of a mechanical lift for all transfers and toileting needs.

A progress note, contained within the clinical health record, (for a specific date and time), indicated that resident #027 was transferred onto the commode by staff using the mechanical lift; staff attached a call bell to the residents clothes and left the resident unattended on the commode. Staff later returned to discover resident #027 on the floor with the mechanical lift still attached to the resident.

As per the progress note, dated for a specific date, resident #027 did not sustain injury during this falls incident.

Personal Support Worker (PSW) #108 indicated (to the inspector) that the mechanical lift was left attached to resident #027, during the identified fall incident. PSW #108 indicated (to the inspector) we are not supposed to leave the mechanical lift attached to residents who are cognitively impaired when on the toilet. PSW #108 indicated he/she was not present during the identified fall incident, but indicated, that it has been the practice, of staff, to leave residents attached to mechanical lifts while on toilets and commodes.

The Director of Resident Care (DRC) indicated (to the inspector) that during the identified fall incident, two staff had toileted the resident #027, and then left resident attached to the lift, left the room to complete other tasks and returned to find resident #027 on the floor. Director of Resident Care indicated that staff are not to leave residents on toilets and or on commodes with the mechanical lifts (and sling) still attached. [s. 36.]

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 there is a process in place and monitored, ensuring staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff have received retraining annually relating to the following, the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect, duty to make mandatory reports under section 24, whistle-blowing protections, minimizing the restraints of residents, fire prevention and safety, emergency and evacuation procedures, infection prevention and control, all acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the staff members responsibilities.

Related to Intake #021905-16:

During dates of this inspection, Inspector #554 observed medication administration and inspected upon a fall incident, involving resident #027; the inspector noted non-compliance, and requested the annual retraining records for Falls Prevention and Management and Infection Prevention and Control, specific to care staff.

The CEO provided (the inspector) with the annual retraining statistics for 2015, which included Falls Prevention and Management, Infection Prevention and Control topics, as well as all other retraining statistics for both 2015 and 2016. The retraining statistics provided, by the CEO, demonstrated that not all staff were provided annual retraining in 2015. The CEO indicated (to the inspector) that only 72 of the 103 staff were provided retraining on the above related topics, in 2015.

Approximately 28 percent of staff were not provided annual retraining in 2015. [s. 76. (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 there is a process in place and monitored, to ensure all staff have received retraining annually relating to the following, the Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect, duty to make mandatory reports under section 24, whistle-blowing protections, minimizing the restraints of residents, fire prevention and safety, emergency and evacuation procedures, infection prevention and control, all acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the staff members responsibilities, to be implemented voluntarily.

WN #8: 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 failed to ensure that drugs are stored in an area or a medication cart that is, secure and locked.

On an identified date, during this inspection, a topical antibiotic, prescribed for resident

#025, was observed (by the inspector) sitting on top of the medication cart. The medication cart was observed unattended in front of the dining room, adjacent to a resident lounge. The medication cart, with the topical antibiotic was observed unattended; Registered Practical Nurse #101 was observed returning to the medication cart from down the hallway.

During this observation, residents and visitors, to the long-term care home, were observed walking by or sitting next to the medication cart.

Registered Practical Nurse #101 indicated (to the inspector) that he/she had been in a resident's room, down the hall. RPN #101 indicated being aware that medication, which included topical drugs, were not to be left unattended. [s. 129. (1) (a)]

2. On an identified date during this inspection, a bottle of antacid was observed (by the inspector) on a table, by a lounge chair, in resident #008's room. The medication was not safely stored (not locked or secured). Resident #008 shares a room with a co-resident.

Resident #008 indicated (to the inspector) that he/she self-administers a medicated spray (vasodilator) and keeps the medicated spray at his/her bedside during the night, on a table; resident #008 keeps the medicated spray in his/her pocket during the day. Resident #008 indicated not having a lockable area to store either of the drugs. Resident #008 is cognitively well.

The inspector observed the bottle of medicated spray, belonging to resident #008, on an identified date.

The health care record, specifically the physician's orders (Order Summary Report), for resident #008 was reviewed. There was no physician's order for the antacid nor was there an order for the self-administration of the medicated spray.

Registered Nurse (RN) #103 indicated (to the inspector) being aware that resident #008 has the medicated spray in his/her room. RN #103 indicated not being aware as to how the medication is stored, once in the resident's room.

3. The home's policy, Expiry Date Policy directs that, an identified medicated eye drop is to be kept in the refrigerator; and that the medication is good for six weeks once opened.

On two separate dates during this inspection, the medicated eye drops were observed in

the top drawer of the medication cart; the medication was opened, and in use for resident #053. The medicated eye drops were not identified as to date opened by registered nursing staff and or date of expiration once opened. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring drugs are stored in an area or a medication cart that is, secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

s. 131. (6) Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(a) the use of the drug; O. Reg. 79/10, s. 131 (6).
(b) the need for the drug; O. Reg. 79/10, s. 131 (6).
(c) the need for monitoring and documentation of the use of the drug; and O. Reg. 79/10, s. 131 (6).
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7). O. Reg. 79/10, s. 131 (6).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Related to Resident #008:

On an identified date during this inspection, a bottle of antacid was observed, by the

inspector, on a table by a lounge chair in resident #008's room.

Resident #008, who is cognitively well, indicated (to the inspector) that he/she self-administers the antacid, when he/she is experiencing an identified problem. Resident #008 indicated that he/she takes the antacid at least weekly. Resident #008 indicated that staff are aware that I take the antacid, but my family supply the antacid.

The health care record, specifically the physician's orders (Order Summary Report), for resident #008 was reviewed. There was no physician's order for the antacid.

The Director of Resident Care indicated (to the inspector) a resident should not be taking medications unless it is prescribed by a physician and or nurse practitioner. [s. 131. (1)]

2. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Registered Nurse (RN) #103, who is designated as the Charge Nurse indicated (to the inspector) there are some residents who self-administer medications in the home. RN #103 indicated, that resident #008 self-administers a vasodilator spray (medication).

Resident #008, who is cognitively well, indicated (to the inspector) that he/she self-administers the identified medicated spray. Resident #008 indicated the medication was given to him/her by the registered nursing staff of the long-term care home. Resident #008 showed the bottle of medication to the inspector; the bottle, medication, had a pharmacy label attached to the bottle. The label on the medication was dated for a specific date, and indicated resident #008 was a resident of the long-term care home.

Resident #008 indicated (to the inspector) that he/she keeps the medicated spray with him/her at all times, either in his/her pocket or at his/her bedside, on the table. Resident #008 indicated that he/she takes the medication when he/she is experiencing an identified discomfort. Resident #008 indicated that he/she has taken the medicated spray this past year; resident #008 indicated that he/she was having some difficulty last week during the night and took the medicated spray, and then rang his/her call bell for assistance.

The health care record, specifically the physician's orders (Order Summary Report) and Consent for Unsupervised Self-Administration of Prescribed Drug, were reviewed for

resident #008. Records failed to provide approval for the self-administration of the medicated spray, by the resident's physician and or nurse practitioner; the health care record further failed to provide support of any consultation taking place between resident #008 and or the prescriber (physician and or nurse practitioner).

There was no documentation in the electronic medication administration records and or in the progress notes, specific to resident #008 having self administered the medicated spray or having had an identified discomfort in the past week (and or weeks prior), as indicated by the resident.

The Director of Resident Care (DRC) indicated (to the inspector) not being aware that any residents in the long-term care home were self administering any oral medications. DRC indicated (to the inspector), that resident #008 should not be self-administering the identified medication without consultation by the physician and or nurse practitioner. [s. 131. (5)]

3. The licensee has failed to ensure that where a resident is permitted to administer a drug to himself or herself, the licensee ensures there are written policies to ensure residents who do so understands, the necessity for safekeeping of the drug on his or her person or in his or her room.

The home's policy, Prescribed Topical Treatment Creams states the following:

"Topical" means a drug in the form of a liquid, cream, gel, lotion, ointment, spray or powder that is applied to an area of the skin and is intended to affect only the local area where it is applied.

A second policy, Self-Administration of Medication; Residents directs that:

Self-Administration of a medication is permitted by a resident only with the physician's permission and only after the resident is counselled. The registered (nursing) staff will review with resident (includes, but not limited to), safe storage of the drug.

During this inspection, Registered Nurse (RN) #103, who is designated as the Charge Nurse, along with the Nurse Practitioner indicated (to the inspector) that there are some residents who self-administer medications in the home. RN #103 indicated that resident #008 and resident #024 self-administer a topical analgesic gel.

The health care record, for resident #008 and #024 were reviewed, and provided the following:

- Resident #008 has a physician's order to self-administer, a topical analgesic. The order directs that resident may apply one application transdermally as needed. Resident may rub the topical analgesic to identified areas three times daily PRN. May keep at bedside. There is a consent for "Self-Administration of Prescribed Drug" specific to topical analgesic, the form is signed by resident #008 dated on a specific date. There is no indication on this form, that the use of the drug, need for monitoring and documentation of the use of the drug, or the necessity for safe-keeping of the drug was explained to the resident as there is no signage of such by resident #008 and or registered nursing staff on this consent form (area is blank).

- Resident #024, has a physician's order to self-administer, a topical analgesic gel. The order directs that resident may apply to areas of discomfort, as needed. May self-administer; may apply three times daily as needed. May keep at bedside and may self-manage administration. There is a consent for "Self-Administration of Prescribed Drug" specific to topical analgesic, the form is signed by resident #024 on an identified date , and is signed by a registered nursing staff (same date). On this consent, there is documentation to support that resident #024 and a registered nursing staff have acknowledged, discussion that the use of the drug, need for monitoring and documentation of the use of the drug, or the necessity for safe-keeping of the drug was explained to the resident.

Both residents (#008 and #024) indicated (to the inspector) that they self-administer the topical analgesic gel. Resident #008 indicated that he/she keeps the topical analgesic on his/her bedside table. Resident #024 indicated that he/she keeps the analgesic on the vanity in the washroom, or inside his/her bedside table. Neither resident #008 and or #024 recall direction, from registered nursing staff or others, as to the safe-keeping of the topical analgesic.

Registered Nurse #103 indicated (to the inspector) that registered nursing staff do not provide counselling or discussion to the residents about self-administration, including drug use, need for the drug, monitoring or documentation of drug usage, nor do registered nursing staff discuss the necessity for safe-keeping of the drug. RN #103 indicated no awareness of where residents store medicated topical creams and or ointments once in the resident's room.

The Director of Resident Care (DRC) indicated (to the inspector) not being aware that drugs, including topical drugs are to be securely stored in resident rooms. [s. 131. (6)]

4. The licensee has failed to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident.

Related to Resident #008:

During this inspection, Registered Nurse (RN) #103, who is designated as the Charge Nurse indicated (to the inspector) that there are some residents who self-administer medications in the home. RN #103 indicated that resident #008 self-administers vasodilator spray (medication).

Resident #008 indicated (to the inspector) that he/she self-administers medicated spray. Resident #008 indicated the medicated spray was given to him/her by the registered nursing staff of the long-term care home. The pharmacy label on the medicated spray was dated for a specific date, and indicated resident #008 was a resident of the long-term care home.

The health care record, specifically the physician's orders (Order Summary Report) was reviewed for resident #008. The physician order's failed to provide approval for the self-administration of the medicated spray, by resident's physician and or nurse practitioner.

The Director of Resident Care (DRC) indicated (to the inspector) that she herself was not aware of any residents self administers oral medications. DRC indicated (to the inspector) that resident #008 should not be self-administering the the medicated spray without the approval of physician or nurse practitioner. [s. 131. (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 there is a process in place and monitored,ensuring hat no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident; that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident; and, that where a resident is permitted to administer a drug to himself or herself, the licensee ensures there are written policies to ensure residents who do so understands, the necessity for safekeeping of the drug on his or her person or in his or her room, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received additional training in the following area, falls prevention and management, skin and wound, continence care and bowel management, pain management, including the recognition of pain, and the application, use and potential dangers of restraining devices and PASDs.

Related to Intake #021905-16:

While inspecting a fall incident, involving resident #027, an inspector requested the annual retraining records for Falls Prevention and Management for care staff.

The CEO provided (the inspector) with the annual retraining statistics for 2015, which included Falls Prevention and Management, as well as all other retraining (mandatory) statistics.

The CEO indicated (to the inspector) that not all direct care staff were provided additional training, specific to the above topics, in 2015.

According to statistic provided, twenty-eight percent of direct care staff were not provided identified additional training. [s. 221. (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 there is a process in place and monitored, ensuring all staff who provide direct care to residents received additional training in the following area, falls prevention and management, skin and wound, continence care and bowel management, pain management, including the recognition of pain, and the application, use and potential dangers of restraining devices and PASDs, to be implemented voluntarily.

WN #11: 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 the annual Infection Prevention and Control program evaluation, included the names of the persons who participated.

After review of the licensee's Infection Prevention and Control program evaluation, evidence of the names of the persons who participated in the evaluation could not be found. The Director of Resident Care was unable to provide the names of persons who participated with certainty. [s. 229. (2) (e)]

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

The home's policy, Hand Washing states that staff will practice strict hand washing procedures. Staff are trained during orientation and annually thereafter in the "Just Clean Your Hands" program. The policy directs will wash or disinfect their hands, following the "4 Moments of Hand Hygiene" which includes, before resident /resident environment contact.

During this inspection, a noon medication pass was observed by an inspector:

- Registered Practical Nurse (RPN) #102 was observed administering medications to three residents (#009, 022 and 023) in the hallway, outside of the dining room, without performing hand hygiene before or after contact with the resident and or resident's environment.
- RPN #102 was observed an hour later (approximate, same date and same location) administering medications to another three residents; RPN #102 did not perform hand

hygiene before or after resident or resident environment contact.

Registered Practical Nurse (RPN) #102 indicated (to the inspector, on the same date) that he/she was aware of required hand hygiene practices between residents, but must have forgotten to perform hand hygiene, as was focusing on correctly administering medications to residents.

Director of Resident Care (DRC) indicated, RPN #102 has been provided hand hygiene training. DRC indicated all staff are required to follow the 4 Moments of Hand Hygiene program.

3. During this inspection, an inspector, observed a nose hair trimmer in the drawer of the tub room, on an identified resident home area; tiny black hairs were visible on the trimmer edges. The nose hair trimmer was not labelled for individual resident usage.

Personal Support Worker (PSW) #110 indicated (to the inspector) that the nose hair trimmer is used for five to six male residents, residing on that resident home area. PSW #110 indicated that he/she was not aware of any policy and or procedure in place to clean or sanitize the nose hair trimmer. PSW #110 indicated that the nose hair trimmer is owned by the long-term care home.

A second pair of nose hair trimmers were located on a second resident home area.

Registered Nurse #103, who is the lead for the Infection Prevention and Control Program, was not available for an interview.

The Director of Resident Care (DRC), who oversees the nursing services and resident care and services, indicated (to the inspector) there was no policy or procedure in place for the nose hair trimmers. DRC indicated, PSW #110 indicated that the nose hair trimmers had been in use for over a year. [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 there is a process in place and monitored, ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to have, his or her personal health information within the meaning of Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, has been fully respected and promoted.

On an identified date and time during this inspection, the computer terminal for the eMAR (electronic medication administration record) was observed (by the inspector) unlocked and visible to co-residents, and visitors to the long-term care home. The computer terminal containing the eMAR, was located on top of and affixed to the medication cart. The unlocked computer terminal was displaying personal health information (PHI) specific to resident #026 and was observed outside of the dining room and adjacent to a resident lounge.

Resident #026's, personal health information, visible detailed the following:

- Date of birth;
- Allergies;
- Advanced Directives;
- Medications (specifically identified) - which spoke to resident #026's medical diagnosis or rationale for administration the medication.

The computer terminal was unlocked and displaying resident #026's personal health information, for approximately seven minutes, before Registered Practical Nurse #101 returned to the medication cart.

Residents and Visitors were observed walking past the medication cart, with the unlocked computer terminal, which was displaying resident #026's personal health information.

Registered Practical Nurse (RPN) #101 indicated (to the inspector) awareness that the computer terminal was not to be left unlocked when staff were not present. RPN #101 indicated being aware that personal health information was to be kept confidential and not visible to other residents and or visitors.

Director of Resident Services indicated (to the inspector) that all staff have been provided training to lock computer terminals when not in attendance in an effort to keep PHI secure. [s. 3. (1) 11. iv.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure the resident's desired bedtime and rest routine is supported and individualized to promote comfort, rest and sleep.

Related to resident #009:

Resident #009's is cognitively well.

The plan of care, for resident #009, specifically the written care plan (last reviewed on a specific date) indicated the following:
- Rest/Sleep Pattern - interventions include, prefers to go to bed at a specific hour.

Resident #009 indicated (to the inspector) that he/she never indicated his/her preference for bedtime as being the hour indicated in an identified plan of care (which was reviewed by the inspector). Resident #009 indicated that his/her preference is to be put into bed after an identified hour. Resident indicated that he/she cannot sleep if put to bed before this time.

Resident #009 indicated, that some staff put me to bed before my requested time, even when I tell them not too; some of the staff tell me you have to go to bed. Resident indicated a personal support worker put him/her to bed a month ago at an undesired time, despite his/her request. Resident #009 indicated that he/she has brought this to the Director of Resident Care's attention, but staff continue to put him/her into bed before his/her requested time.

The Director of Resident Care (DRC) indicated (to the inspector) awareness of resident #009's sleep preference. Director of Resident Care stated she did put a memo in the Personal Support Worker's Communication Notes (communication binder) indicating resident #009's sleep time preference. The memo was reviewed and confirmed by the

inspector as being issued by the Director of Resident Care on a identified date.

Director of Resident Care indicated the plan of care had not been updated to reflect resident #009's desired bedtime and or rest routine, until after a November 2016 date, when the concern was addressed, to her, by the inspector.

Director of Resident Care, indicated during a secondary interview (with the inspector) that at times staff have to put resident #009 to bed before her desired sleep time, due to staffing and workload issues. Director of Resident Care acknowledged that this was not as per the resident's desired bedtime and rest routine. [s. 41.]

Issued on this 14th day of December, 2016

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

Original report signed by the inspector.