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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 8, 2015	2015_405189_0010	T-1699-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - RICHMOND HILL
170 Red Maple Road RICHMOND HILL ON L4B 4T8

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

NICOLE RANGER (189), JOELLE TAILLEFER (211), SARAN DANIEL-DODD (116), THERESA BERDOE-YOUNG (596)

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): July 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 2015

The following Complaint inspections were conducted concurrently with this RQI: T-1990-15, T-2144-15, T-2171-15, T-2428-15
The following Critical Incident inspections were conducted concurrently with this RQI: T-2750-15

During the course of the inspection, the inspector(s) spoke with Director of Administration(DOA), Director of Care(DOC), associate director of care(ADOC), environmental service manager(ESM), social worker(SW), registered nurse(RN), registered practical nurse(RPN),registered dietitian(RD), Resident Assessment Instrument Coordinator (RAI coordinator), skin and wound care coordinator, program manager, unit coordinator/scheduler, personal support workers (PSW), housekeeping staff, Family Council Chair, Resident Council President, private sitter, residents and family members.

The following Inspection Protocols were used during this inspection:
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
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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 has failed to set out clear directions to staff and others who provide direct care to the resident.

Review of resident #004’s Minimum Data Set(MDS) record dated May 2015, indicated that the resident can communicate adequately with an assistive device.

Review of the written plan of care dated May 2015, and interview with RPN #118 revealed that the written plan of care did not identify the resident's impaired communication and requirements to use an assistive device.

On an identified date in July 2015, the inspector observed resident #004 using the assistive device.

An interview with PSW #119 revealed the resident uses an assistive device throughout the day and describe the maintenance care of the device.

Interviews with the Director of Care(DOC) and the Director of Administration(DOA) confirmed that the written plan of care and the current Kardex did not identify the resident's impaired communication without his/her assistive device and did not provide clear directions to the staff how to provide resident #004 assistance with his/her assistive device. [s. 6. (1) (c)]

2. Review of resident #006's written plan of care dated June 2015, and interview with PSW #102 revealed that the written plan of care and the current Kardex did not address the use of both quarter side rails when the resident rested in bed.

Interview with resident #006 revealed that both quarter side rails are elevated when he/she rested in bed for safety.

Interview with PSW #131 and DOC revealed that both quarter side rails are used when the resident is placed into bed.

Interviews with the DOA and the DOC confirmed that the written plan of care and the current Kardex did not address that both quarter side rails are used for resident #006 and did not provide clear directions to the staff. [s. 6. (1) (c)]

3. Review of the Critical Incident record submitted to the Ministry of Health and Long Term care on an identified date, indicated an altercation between resident #036 and #037.

Review of resident #036's progress notes indicated the resident used an ambulation device to push, hit or try to hit resident #037, resident #038 and other residents on six identified dates over a two year period, and pushed a resident's wheelchair with an ambulation device on two identified dates in 2015.

Review of resident #036's written plan of care dated April 2015, did not indicate that the resident can be physically aggressive toward another resident by using an ambulation device.

Interviews with PSW #109 and RPN #111 revealed that the resident has been using an

ambulation device to hit residents .

Interview with RPN #111 revealed that the resident's written plan of care did not indicate that staff needs to supervise the resident in the hallway especially when he/she is going or returning from the dining room.

Interview with the DOC confirmed that the resident was using the ambulation device to hit residents. The resident's plan of care did not give clear direction to staff and others until July 2015, during the inspection, to supervise resident #036 to ensure that the resident's ambulation device is not used as a weapon to hit other residents. [s. 6. (1) (c)]

4. Review of resident #009's written plan of care dated June 2015 and the current Kardex indicated the resident requires set up assistance to eat.

Interviews with PSW #120 and RPN #100 revealed that the resident requires feeding assistance and encouragement. The resident will not usually initiate feeding oneself without assistance.

Interviews with the PSW #120, RPN #100 and the DOC confirmed that the ADL's section of the written plan of care and the kardex did not provided clear directions to staff and others who provide direct care to the resident during meal times. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

Review of the progress notes dated November 2014, indicated resident #011 exhibited altered skin integrity. The area was cleansed and a dressing was applied.

Record review of the home policy # V3-1400 titled "Skin Care Program" revised February 2012, indicated to complete a weekly skin assessment for all residents with altered skin integrity and the documentation must include:
-location of area of altered skin integrity,
-Classify the skin breakdown and identify the etiology,
-size of the wound include length, width, and depth: for all wounds stage 2 or higher,
-Periwound area (status of the area surrounding the ulcer),

-Exudate amount, type, and odour,
-Necrotic tissue: colour amount,
-type of tissue expose (dermis, epidermis, muscle etc),
-Undermining and tunneling,
-evidence of infection: erythema, induration, odour,
-pain assessment and
-effectiveness of treatment.

Interview with RPN #100 revealed that the resident's progress notes did not indicate when the alteration in skin integrity was reassessed and healed. Interview with RPN #132 revealed that the altered skin integrity was healed after two days but did not document the assessment and intervention.

Interview with the DOC confirmed that the resident's progress notes did not indicate when the altered skin integrity was healed and the home's expectation is that staff must document the skin assessment and the effectiveness of the treatment. [s. 6. (9)]

6. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Review of resident #011's written plan of care dated June 2015, indicated the resident had two identified areas of altered skin integrity.

Review of the progress notes from December 2014 to July 2015 and the quarterly skin assessment for December 2014, March 2015, and June 2015, did not indicate that the resident has two areas of altered skin integrity.

Interviews with PSW #119 and RPN #100 revealed that the resident's skin is intact and does not have altered skin integrity.

Interviews with RPN #100 and the DOC confirmed the resident's written plan of care was not updated when the resident's care set out in the plan was no longer necessary. [s. 6. (10) (b)]

7. A review of the progress notes for resident #012 dated November 2014, indicated that an area of altered skin integrity developed on an identified area. A review of the progress notes dated December 2014, indicated a second area of altered skin integrity

on the same identified area.

A review of the written care plan dated December 2014, indicated that resident #012 is at risk for altered skin integrity related to decreased mobility and urinary incontinence. The written care plan failed to reveal that resident #012 had an area of altered skin integrity to the identified area which later became progressively worse and did not develop a second area of altered skin integrity.

Interviews with registered staff, Resident Assessment Instrument coordinator (RAI coordinator) and the DOC confirmed that the plan of care was not reviewed and revised when the resident's care need change. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review and interview with resident #006's family member revealed that the resident presently has an identified area of altered skin integrity that developed in May 2015. Record review of resident #006's weekly skin assessments from May to July 2015 revealed that one skin assessment in May 2015 and one skin assessment in July 2015 were not done.

Interviews with registered staff #103 and registered staff #115 revealed that they did not complete resident #006's weekly skin assessments in May and July 2015 and confirmed that they were not done. [s. 50. (2) (b) (iv)]

2. Review of the progress notes dated May 2015, indicated resident #011 sustained skin breakdown on an identified area. The affected area was measured and a dressing was applied on two identified dates in May 2015.

Interviews with RPN #100 and the DOC revealed that the resident’s altered skin integrity was not reassessed on the identified week , by a member of the registered nursing staff and there is no indication when the identified area was healed. [s. 50. (2) (b) (iv)]

3. Record review and staff interview revealed that resident #012 developed an identified area of impaired skin integrity in November 2014. Record review of the skin assessments for resident #012 revealed that weekly skin assessments were not conducted on one date in November 2014, and two dates in December 2014.

Interviews with registered staff #142 and the DOC confirmed that the weekly skin assessments were not conducted for the above mentioned dates for the resident with altered skin integrity. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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 designated staff member to co-ordinate the infection prevention and control program possesses education and experience in infection prevention and control practises.

Interview with the Associate Director of Care (ADOC) who is the lead for the infection prevention and control program reported that the lead does not possess formal education in infection prevention and control practises including infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

Interview with the DOC confirmed that the home will be sending the lead to receive education in the above mentioned areas in September 2015. [s. 229. (3)]

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

On a identified date in July 2015, the inspector requested staff member #100 to assist resident #013 to his/her room for the purpose of conducting a face to face interview. Resident #013 resides in a private room. Upon entry to the resident's room, the main and washroom door were closed and audible noises of toilet flushing were heard from inside the resident's washroom. A voice was heard stating "don't come in, don't come in I am cleaning, I am almost done". Staff member #100 opened the door to the washroom of which staff member #101 exclaimed "don't come in, I am almost done'. Staff member #101 closed the washroom door. Staff member #100 exited the room and left resident #013 and the inspector inside. Staff member #101 continued to state "don't come in, I am almost done cleaning". The toilet bowl was flushed a second time. Staff member #101 exited the washroom and stated that he/she was cleaning the toilet. The inspector did not observe a cleaning cart or cleaning products/equipment within staff member #101 presence or within the room. The inspector inquired about what cleaning products and equipment were used to clean the washroom of which staff member #101 indicated that he/she only cleaned the toilet seat with paper towels.

Interviews held with staff members #100 and #101 revealed that staff #101 was using resident #013's washroom for personal use. Further interviews held with staff members #100, #101 and the DOC confirmed that resident's washrooms are not to be used for personal use and staff #101 did not participate in the implementation of the infection prevention and control program. [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 a staff member to co-ordinate the program who has education and experience in infection prevention and control practises, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management, and to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #4: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

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 to ensure that every residents' right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity is fully respected and promoted.

During observations conducted of lunch service on a identified date in July 2015, the inspector observed PSW #143 assisting resident #029 with his/her lunch meal. Resident #029, began to move his/her head and hands from side to side while staff member #143 was feeding the resident. PSW #143 then stated in a loud tone “I can not feed him/her he/she is moving his/her hands and head a lot, I can not feed him/her”, then proceeded to cover the resident’s meal and left the table. Interviews with 2 identified PSW who was present in the dining room confirmed that the manner in which PSW #143 handled the

incident did not show courtesy and respect to resident #029. [s. 3. (1) 1.]

2. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity.

On an identified date in July 2015, the inspector observed an identified staff member to be using a resident’s washroom for personal use.

Interviews held with staff members #100, #101 and the DOC confirmed that resident's washrooms are not to be used for personal use.

3. The licensee has failed to ensure that every resident has the right to 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,

On an identified date in July 2015, on an identified unit, the inspector observed a Point of Care (POC) monitor in the corridor with the screen displaying a resident's personal health information visible to anyone walking by.

Interview with PSW #139 revealed that the POC monitor should not be left open displaying the resident's personal health information.

Interview with PSW #138 revealed that he/she left the screen open displaying resident's personal health information because the screen was frozen and unable to close at the time. PSW #138 confirmed that he/she should have asked the registered staff for assistance and should not have left the POC open and unattended. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practises, and if there are none, in accordance with prevailing practises to minimize risk to the resident.

Review of resident #006 assessment titled "Centric Health Assessment V1.1_old" dated June 2015, indicated that the resident's support rails were assessed and approved by the physiotherapist in September 2014.

Record review indicated that the resident was admitted to the home in March 2014.

Interview with resident #006 revealed that both quarter side rails are elevated when he/she rested in bed for safety and repositioning.

Interview with RPN #140 and DOC revealed that both middle quarter side rails are used when the resident is placed into bed.

Interview with the DOC confirmed that the resident was admitted in March 2014 and the bed side rails were not assessed until September 2014. [s. 15. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident’s plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident’s physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living included in the residents' plan of care.

Review of the resident #006’s written plan of care dated June 2015, and interview with PSW #102 revealed that the written plan of care and the current Kardex did not address

the use of both quarter side rails when the resident rested in bed.

Interview with resident #006 revealed that both quarter side rails are elevated when he/she rested in bed for safety and reposition.

Interview with RPN #140 revealed that the resident cannot move without assistance to be repositioned in bed.

Interview with RPN #140 and DOC revealed that both middle quarter side rails are used when the resident is placed into bed.

Interview with the DOC confirmed that the written plan of care did not address that both middle quarter side rails are used as a PASD and assist the resident with a routine activity of living for resident #006. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by,
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

Review of resident #006 assessment titled "Centric Health Assessment V1.1_old" dated June 2015, indicated that the resident's support rails were assessed and approved by the physiotherapist on September 2014.

Record review indicated that the resident was admitted to the home in March 2014.

Interview with resident #006 revealed that both quarter side rails are elevated when he/she rested in bed for safety and repositioning.

Interview with RPN #140 and DOC revealed that both middle quarter side rails are used when the resident is placed into bed.

Interview with the DOC confirmed that the resident was admitted in March 2014 and the

bed side rails were not approved until September 2014. [s. 33. (4) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating and drinking are only served a meal when someone is available to provide the assistance.

During observations conducted of lunch service on a identified date in July 2015, on an identified unit, the inspector observed resident #010 was served entrée at 12:18 p.m. The entrée sat in front of him/her at the table until 12:24 pm when staff became available to assist with feeding.

On the same day, resident #026 was served entrée at 12:22 p.m. and did not receive assistance with feeding until 12:27 p.m. Resident #027 was served entrée at 12:28 p.m and did not receive assistance with feeding until 12:34 p.m.

Interviews with the registered and personal support workers confirmed that the meals were served before assistance was available to the residents. [s. 73. (2) (b)]

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the home's 2014 resident and family satisfaction survey revealed that there were no questions to measure the satisfaction of programs provided in the home such as: physiotherapy, skin and wound care, falls, Occupational Therapy (OT), and restraints.

Interview with the ED confirmed that questions to measure the satisfaction with the above mentioned services and programs provided in the home were not included in the 2014 residents' and family satisfaction surveys. [s. 85. (1)]

WN #9: 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 of medication cart that is used exclusively for drugs and drug related supplies and that is secure and locked.

On an identified date in July 2015, during observations of medication pass on an identified unit, the inspector observed various non drug-related items being stored in the medication carts and the double locked narcotics bins. These items included money, five unidentified resident's eyeglasses, and a container of pens and highlighters. Staff interview with the registered staff #136 and DOC confirmed that the medication cart is used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber .

On an identified date in July 2015, the physician had written an order for an identified medication to be administered in a specified manner for seven days for resident #028. On an identified date in July 2015, during observations of the medication pass with staff member #129, the inspector observed the staff to administer the 1200hrs identified medication in a manner contrary to that specified in the order. The inspector observed the medication administration record for the identified date, and order written for the resident to receive the identified medication in a specified manner.

Interviews with registered staff member #129 and registered staff member #144 revealed that they will only administer the medication in the specified manner under particular circumstances . Interview with the DOC confirmed that the medication was not administered to resident #028 in accordance with directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 7th day of December, 2015

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

Original report signed by the inspector.