Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2015	2014_251512_0015	T-014-14	Resident Quality Inspection

Licensee/Titulaire de permis

601091 ONTARIO LIMITED
429 WALMER ROAD TORONTO ON M5P 2X9

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

CEDARVALE TERRACE
429 WALMER ROAD TORONTO ON M5P 2X9

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

TILDA HUI (512), JULIENNE NGONLOGA (502), MATTHEW CHIU (565)

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): September 16, 17, 19, 22, 23, 24, 25, 26, 29 and 30, 2014.

Additional inspection related to the following Log# was also completed during this inspection: T-1033-14, complaint.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care(DOC), nurse manager, associate nurse manager, registered nurse (RN), registered practical nurse(RPN), personal suppport worker(PSW), registered dietitian(RD), food service manager(FSM), environment service manager(ESM), maintenance staff, registered physiotherapist(PT), occupational therapist(OT).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

Findings/Faits saillants :

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

Observation made on September 17, 2014, at 1:30 p.m. revealed that resident #006 had a purplish bruise, with size one inch by one inch, on the back of his/her left hand. The resident stated that the resident banged his/her hand somewhere but cannot recall when and where. The resident stated that the doctor at the home had seen the bruise and said it will go away. Observation made on September 24, 2014, at 1:20 p.m. noted that the resident had new pinkish bruise on top of his/her old bruise on the back of his/her left hand. The new bruise was similar in size to the old bruise. The resident stated that he/she must have banged his/her hand somewhere but cannot remember when and where.

Record review revealed no evidence of interventions set up in the plan of care to address the issue of bruises of the resident.

Interview with an identified registered nursing staff confirmed that interventions were not established to address the issue of bruises of the resident. The staff was not aware that the resident had bruises on the back of his/her left hand. [s. 6. (1) (c)]

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

On September 24, 2014, the following was observed during the lunch meal service:
- resident #021 was served pureed carrot while the resident's diet order requires him/her to have food with minced texture.
- resident #022 was served lactaid milk, the resident's diet order requires him/her not to have lactaid milk at lunch.
- resident #023 was served regular carrot and raisins salad, the resident's diet order requires him/her to have minced salad.

Interview with an identified PSW confirmed that the residents received wrong diets. The PSW acknowledged that he/she served the residents without referring to the residents' diet list. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation.

On September 16, 2014, the call bell in the television (TV) room on the sixth floor was observed covered by a large picture frame, preventing calls to be cancelled at the point of activation.

Staff confirmed that the call bell can be activated but the call cannot be cancelled at the point of activation. Maintenance staff was called and the picture frame was removed. [s. 17. (1) (c)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On September 16, 2014, the salon in the basement level and the bistro on the main floor were observed not being equipped with a resident-staff communication and response system.

Interview with ESM and administrator confirmed that the call bells were not available in the salon and bistro and these two areas were accessible by the residents. [s. 17. (1) (e)]

3. The licensee has failed to ensure that the resident-staff communication and response system clearly indicate when activated where the signal is coming from.

The licensee uses a resident-staff communication and response system that when resident pulls the call bell cord, it activates the system.

1. Observation conducted on September 17, 2014, in an identified resident's room revealed that the call bells for beds A and B were not working and did not indicate any visual or auditory signal when activated. The call bell cords from bed A and bed B were channeled to pass through an anchor before attached to a switch on the wall. The anchor was not affixed to the wall.

Interview with the nurse manager and maintenance staff confirmed that the call bells for beds A and B did not indicate any signal when activated. The anchor of the cords should be affixed to the wall in order for the call bells to function.

2. Observation conducted on September 19, 2014, in a second identified resident's room revealed that the call bell in the bathroom was not working and did not indicate any visual or auditory signal when activated. The call bell cord was attached to a switch located

behind the toilet. The cord passed through six wall anchors and ended on the left side of the toilet for resident to activate the call bell.

Interview with an identified PSW and maintenance staff confirmed that the call bell was not functional. The call bell could not be activated when the cord was pulled because the cord was jammed. [s. 17. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation, that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, and that the resident-staff communication and response system clearly indicate when activated where the signal is coming from, to be implemented voluntarily.

WN #3: 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 a resident exhibiting altered skin integrity including bruises received 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.

Observation made on September 17, 2014, at 1:30 p.m. revealed that resident #006 had a purplish bruise, size one inch by one inch, on the back of his/her left hand. The resident stated that he/she banged his/her hand somewhere but cannot recall when and where. The resident stated that the doctor had seen it and said it will go away. Observation made on September 24, 2014, at 1:20 p.m. noted a new bruise, pinkish in color, on top of the old bruise on the back of the resident's left hand with similar size as the old bruise. The resident stated that he/she must have banged his/her hand somewhere but cannot remember when and where.

Record review revealed no evidence of any skin assessment conducted on September 17 and 24, 2014, on the bruises of the resident.

Interview with an identified registered nursing staff confirmed that skin assessments were not conducted on the resident's bruises. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Record review revealed that registered nursing staff identified resident #002 to have an open area on his/her right buttock on October 31, 2013. There was no presence of any referral made to registered dietitian (RD) nor any evidence of an assessment by the RD. The RD's assessments for skin breakdown were conducted on April 15 and May 20, 2014, but not on or after October 31, 2013, at the identification of the pressure ulcer.

Interview with an identified registered nursing staff confirmed that there was no referral made to RD upon identification of the pressure ulcer, and therefore the RD did not assess the resident after October 31, 2013. [s. 50. (2) (b) (iii)]

3. Observation made on September 17, 2014, at 1:30 p.m. identified that resident #006

had a purplish bruise, size one inch by one inch, on the back of his/her left hand. The resident stated that he/she banged his/her hand somewhere but cannot recall when and where. The resident stated that the doctor had seen it and said it will go away. Observation made on September 24, 2014, at 1:20 p.m. noted new bruise, pinkish in color, on top of old bruise on the back of the resident's left hand with similar size as the old bruise. The resident stated that he/she must have banged his/her hand somewhere but cannot remember when and where.

Record review revealed no evidence of any referral made to RD on or after September 17 or 24, 2014, related to the bruises of the resident.

Interview with an identified registered nursing staff confirmed that there was no evidence of any RD referral related to the bruises, and therefore, the RD did not assess the resident after September 17 and 24, 2014. [s. 50. (2) (b) (iii)]

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

Record review revealed that resident #002 developed a stage 2 pressure ulcer on his/her right buttock on October 31, 2013. Weekly skin assessment were not conducted during the period between March 25 to April 15, 2014 when the pressure ulcer remained open.

Interview with an identified registered nursing staff confirmed that weekly skin assessments were not conducted during the above mentioned period. [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 resident exhibiting altered skin integrity including bruises received 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, that the resident exhibiting altered skin integrity, including pressure ulcers been assessed by a registered dietitian who is a member of the staff of the home, and the resident exhibiting altered skin integrity, including pressure ulcers been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Councils in developing and carrying out the satisfaction survey.

Record review and interview with the Residents' Council's president revealed that the licensee reviewed the result of 2013 satisfaction survey with the council but they did not seek the advice of the council in developing and carrying out the satisfaction survey.

Interview with the programs manager and administrator confirmed that they did not seek advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

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 advice of the Residents' Council were sought in developing and carrying out the satisfaction survey, to be implemented voluntarily.

WN #5: 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:
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 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 has failed to ensure that resident's right to keep personal possessions in his/her room is fully respected and promoted.

Interview with resident #016 revealed that the resident's room was searched by the home's staff without his/her prior agreement, and the resident's belonging, mainly a pair of safety scissors, was removed while he/she was away at a medical appointment.

Interview with an identified PSW, a registered nursing staff and the administrator confirmed the search did occur in August 2014, and a pocket knife was removed from the resident's room. The home's staff indicated that the search was requested by one of the resident's family members who was concerned that the resident had voiced suicidal ideation. The home's staff confirmed that they did not seek the resident's prior consent before conducting the search even though the resident was cognitively capable of giving such consent. [s. 3. (1) 10.]

2. The licensee failed to ensure that each resident has the right to have his or her personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation made on September 22, 2014, at 10:10 a.m. revealed that the personal health information for an identified resident was displayed on the eMAR screen on the medication cart in the lounge while the registered nursing staff was not present.

Interview with an identified nursing staff confirmed that he/she left the eMar screen on with the resident's PHI displayed in the lounge while speaking to a family member in the hallway. [s. 3. (1) 11. iv.]

WN #6: 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 is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practises, to minimize risk to the resident.

Observation made on September 19, 2014, in an identified resident's room, revealed that one quarter bed rail was in the up position for resident #002. A review of the written plan of care indicated that the use of the bed rail was to assist resident's bed mobility.

Record review and interview with registered nurses and physiotherapist confirmed that the resident was not assessed for the use of the bed rail. [s. 15. (1) (a)]

2. Observation made on September 22, 2014, in a second identified resident's room, revealed that two quarter bed rails were in the up position for resident #009. A review of the written plan of care indicated that the use of the bed rails was to assist resident's bed mobility.

Record review and interview with registered nurses and physiotherapist confirmed that the resident was not assessed for the use of the bed rails. [s. 15. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is kept clean and sanitary.

On September 16 and 30, 2014, the following were observed:
• The tub room's floor on the second floor was dirty and there was stain around the plumbing, and
• Tub room's floor on the fourth floor was dirty and the tub was dirty and stained.

Review of the cleaning schedule revealed that the tub rooms should be cleaned daily.

Interview with the ESM confirmed that the tub room was not cleaned and should be clean weekly on Friday. The ESM indicated that the tub rooms are not being used currently for bathing. Nursing staff are using the tub rooms for storage, making it difficult for the environmental staff to clean the floor. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home is maintained in a good state of repair.

On September 16, 2014, the following were observed:
• The ceiling tiles in the Synagogue and activity's room were stained and had mould,
• The paint behind the door in the shower room on an identified floor was peeling off,
• The wall in the dining room on an identified floor was scratched, and
• The wall by the window in an identified resident's room had a large bubble caused by water infiltration.

Interview with the ESM and maintenance staff indicated that the home had water infiltration in the walls and ceiling. The cause of water leakage had been fixed, and the home has a plan in place to replace the stained ceiling tiles and paint the damaged walls. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review and interview with a representative of the Residents' Council revealed that the licensee did not respond in writing within 10 days of receiving the council's concerns raised on July 31, and May 29, 2014, during the council's meetings.

Interview with the administrator confirmed that the licensee uses a concern form to record the council's concern and written response from the home. The licensee reviewed the response with the council on August 18, and June 26, 2014, 18 days and 28 days later, but not within 10 days of receiving the council's concerns as required. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

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

Record review and interview with a representative of the Family Council revealed that the licensee did not respond in writing within 10 days of receiving concerns raised on August 11, and June 9, 2014, during the council's meetings.

Interview with the administrator confirmed that the licensee uses a concern form to record the council's concern and written response from the home. The licensee reviewed the response with the council on September 9, and August 11, 2014, 31 days and 63 days later, but not within 10 days of receiving the council's concerns as required. [s. 60. (2)]

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there are appropriate furnishings and equipment in resident dining areas, including tables at an appropriate height to meet the needs of all residents.

On September 16, 2014, residents #17 and #20 were observed each sitting in their wheelchairs, and the height of the dining room tables were at the same level as the residents' shoulders.

Staff interview including nurse manager, PT, OT, and RD, confirmed that the residents' sitting positions during meals were very low to meet the needs of the residents. The OT indicated that some homes provide adjustable table for the residents to use, however these tables are not available in this home. [s. 73. (1) 11.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observation made on September 22, 2014, noted that these reports were not posted but instead were filed in a binder and placed at the information desk located in the lobby. The binder included the service agreements, inspection reports, auditor's reports, health and safety, emergency policies, and contact information.

Interview with the administrator confirmed that inspection reports for the past two years were not posted in the home for the public's easy viewing. [s. 79. (3) (k)]

WN #12: 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 medication cart that is secure and locked.

The inspector observed on September 22, 2014, at 10:10 a.m., the medication cart unlocked and unsupervised in the TV area. Three plastic packages containing tablets were observed on top of the medication cart. Ten residents were present in the TV area while the registered nursing staff was in the hallway talking with a family member.

Interview with an identified nursing staff confirmed that he/she left the medication cart unlocked and unsupervised while speaking to a family member in the hallway. [s. 129. (1) (a) (ii)]

WN #13: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are provided training in skin and wound care.

Record review revealed that 29% of direct care staff did not receive training in skin and wound care in 2013.

Interview with the associate nurse manager who is the lead for the skin and wound program confirmed that 29% of direct care staff did not receive the training in 2013. The home has a plan to train 100% of direct care staff in 2014. [s. 221. (1) 2.]

Issued on this 14th day of January, 2015

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

Original report signed by the inspector.