Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JUNE OSBORN (105), CHRISTINE MCCARTHY (588), SALLY ASHBY (520)
Inspection No. / No de l'inspection :	2014_181105_0038
Log No. / Registre no:	L-001190-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 9, 2014
Licensee / Titulaire de permis :	GROSVENOR HEALTH CARE PARTNERSHIP (NO. 3) 150 WATER STREET SOUTH, CAMBRIDGE, ON, N1R-3E2
LTC Home / Foyer de SLD :	MAITLAND MANOR 290 SOUTH STREET, GODERICH, ON, N7A-4G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kyla MacDonald

To GROSVENOR HEALTH CARE PARTNERSHIP (NO. 3), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_260521_0013, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The Licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that there at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Review of the Registered Nurses Schedule revealed on September 22, 23, and 25, 2014 1 Registered Nurse was scheduled and worked 0600-1400; and on September 24, 2014, 2 Registered Nurses were scheduled and worked 0600-1400 and 2200-0600.

An interview with the Director of Care indicates there has been attempts made to recruit and has offered documentation to support this, however, she confirms there is not Registered Nurse coverage available in the home at all times.

This area of non-compliance was previously issued as a an Order March 14, 2014. (105)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JUNE OSBORN

Service Area Office /
Bureau régional de services : London Service Area Office

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 9, 2014	2014_181105_0038	L-001190-14	Resident Quality Inspection

Licensee/Titulaire de permis

GROSVENOR HEALTH CARE PARTNERSHIP (NO. 3)
150 WATER STREET SOUTH, CAMBRIDGE, ON, N1R-3E2

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

MAITLAND MANOR
290 SOUTH STREET, GODERICH, ON, N7A-4G6

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

JUNE OSBORN (105), CHRISTINE MCCARTHY (588), SALLY ASHBY (520)

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 23, 24, 25, 26, 29, 30, and October 1, 2014

During this Resident Quality Inspection, a concurrent critical incident was inspected under Log #000168-14.

During the course of the inspection, the inspector(s) spoke with 44 Residents, 6 Family Members, 2 Housekeeping Aides, 3 Dietary Aides, 10 Personal Support Workers, 5 Registered Practical Nurses, 3 Registered Nurses, the Resident Assessment Instrument Coordinator, the Programs Manager, the Environmental Manager, the Dietary Manager, the Director of Care, and the Administrator.

During the course of the inspection, the inspector(s) toured the Resident areas of the home, observed resident/staff interactions, meal service and medication administration, inspected medication storage areas, reviewed clinical records, staffing schedules and other applicable documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Review of the Registered Nurses Schedule revealed on September 22, 23, and 25, 2014, 1 Registered Nurse was scheduled and worked 0600-1400; and on September 24, 2014, 2 Registered Nurses were scheduled and worked 0600-1400 and 2200-0600. No other Registered Nurses were scheduled to work on these dates.

An interview with the Director of Care indicated there have been attempts made to recruit and provided documentation to support this, however, she confirmed there is not Registered Nurse coverage available in the home at all times. [s. 8. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

A review of the current "Care Plan", the accompanying Kardex, and documentation of the care provided for an identified resident indicated clear directions regarding toileting were not given to the staff and others who provided care to this resident.

The Director of Care verified that the Kardex, "Care Plan", and charting did not indicate a toileting routine has been established, and confirmed clear directions were required. [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.

Review of plan of care indicated an identified resident was to receive treatment by physiotherapy staff.

Review of the Progress Notes revealed that the required treatment was not provided to this resident.

The physiotherapist verified that the treatment had not been provide for the identified resident.

The Administrator confirmed the treatment should have occurred. [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 plans of care provide clear direction, and the care set out in the plan is provided to the resident, to be implemented voluntarily.

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(b) complied with,

a) A review of the Medical Pharmacies Pharmacy Policy & Procedure Manual for LTC Homes, Section 5, Policy:5-1, Expiry and Dating of Medications, page 1 of 1, Date:01/14, reveals that the Procedure includes the following: Remove any expired medications from stock and order replacement if necessary.

On September 29, 2014 at 1045 hours, an expired Td Adsorbed 5x 0.5 ml., dated June 2014 was found in the Vaccine Fridge.

A Registered Practical Nurse verified that the vaccine was expired and confirmed that the expectation of the Home is that there should be no expired vaccines in the Vaccine Fridge.

The Director of Care confirmed that the expectation of the Home is that there should be no expired vaccines in the Vaccine Fridge.

b) A review of the Medical Pharmacies Pharmacy Policy & Procedure Manual for LTC Homes, Section 2, Policy:2-4, Emergency Starter Box, page: 1 of 6, Date: 01/14, reveals that the Policy includes the following : Contents of Emergency Starter Box must match the inventory monitoring sheet. All packs must be accounted for.

On September 29, 2014, the Emergency Drug Box contents and the Emergency

Starter Box Master List were found to not coincide. The following were listed on the Emergency Starter box Master List but not found in the contents of the Emergency Drug Box:
Acetaminophen/Codeine (Lenoltec #2, Tylenol #2) 300/15mg
Acetaminophen/Codeine (Lenoltec #3, Tylenol #3) 300/30 mg
Diazepam 10mg/2ml
Hydromorphone (Dilaudid) 2mg/ml injection
Morphine 15 mg/ml injection
Gentamicin (Garamycin) 0.3 % eye drops
The following were found in the Emergency Drug Box and were not listed on the Emergency Starter Box Master List:
Epipen (1mg/ml)
Isopto Atropine vials (2)

Two different Registered Practical Nurses verified that the medications listed on the Emergency Starter Box Master List and the contents of the Emergency Drug Box did not coincide and that it is the expectation of the Home that the List be accurate.

The Director of Care confirmed that the expectation of the Home is that the contents listed in the Emergency Drug Box Master List must coincide with the contents in the Emergency Drug Box. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted is complied with, 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 kept clean and sanitary.

On September 30, 2014, 16 out of 23 or 70% of wall mounted fans in the following Common areas were noted to be dusty or covered with debris. This included:the Florida Room, Activity Room, outside the Poplar Dining Room, North Hallway(by rooms 1-5), North Hallway(by rooms 6-9), West Hallway(rooms 12-15), West Hallway (rooms16-27), South Hallway(rooms 38-42), Serenity Spa.
2 Housekeeping Aides verified the dusty and debris covered wall mounted fans, sharing there is scheduled time for all cleaning, but not one that specifies when the fans would be done.
The Environmental Manager confirmed fans are not on a specific schedule, but should be included in the regularly scheduled routine. [s. 15. (2) (a)]

Additional Required Actions:

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

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 has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During room observations on September 23 and 24, 2014, 5 beds with bed rails had issues with mattresses sliding side to side and/or top to bottom:

Review of a Cardinal Health Bed Assessment done for the home (not dated) does not deal with entrapment zones but infection issues pertaining to worn mattresses. The Environmental Manager has begun an audit of bed entrapment risk for all beds in the home, but identified it is not complete.

The Environmental Manager verified that the mattresses did slide side to side and/or bottom to top as some were missing corner guards and others which had the guards the mattress was not tucked into. [s. 15. (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 that were bed rails are used, steps are taken to prevent resident entrapment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents and cannot be opened more than 15 centimetres.

During the tour and room observations, several windows were noted to open more than 15cm.

Window openings were verified by the Administrator who noted the limiter on some windows had been broken and needed replacement. The Administrator confirmed the expectation of the home was that every window in the home that opens to the outdoors and is accessible to residents and cannot be opened more than 15 centimetres. [s. 16.]

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 windows that open to the outdoors and is accessible to residents and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #7: 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, (f) clearly indicates when activated where the signal is coming from.

a) On September 23, 2014 during the initial tour of the home, it was noted the call bell in the Florida Dining Room and Florida TV room to not light up on the enunciator panel. The Administrator stated the panel (which is outside the nursing station) is used by staff to identify where a call bell has been activated. The Administrator verified that these two home areas were not labeled on the enunciator panel and did not light up on the panel when the call bell was activated. She further confirmed the expectation of the home was to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from.

b) Observation of a resident room revealed that neither call bell would activate the communication-response system. The staff pagers did not alarm nor did it show on the enunciator panel. 2 Personal Support Workers verified the bells did not work. The Administrator confirmed this call bell should be working and immediately called the Environmental Manager to repair it. An electrician was called in and a temporary fix was accomplished since the break could not be located.
This call bell was repaired October 1,2014. [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 the resident-staff communication system clearly indicates were the signal is coming from, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, unless contraindicated by a medical condition.

Medical record reviews revealed that 5/41 baths or 12% of baths for 6 residents over a 5 week period were not completed as stated in the plan of care.

Interview with a resident confirmed this issue was discussed at Residents' Council.

Resident Council Minutes confirm this issue has been discussed and responded to by Management.

The Director of Care confirmed there are issues getting all the baths done on certain days even with strategies in place. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at least twice a week by method of choice, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

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

On September 25, 2014 the Harmony Spa Room door was found propped open and unattended.
Inside the Spa was an unlocked cupboard with ED disinfectant inside.
The Administrator verified the door should not be propped open and that residents had access to a hazardous chemical.
The Administrator confirmed the expectation of the home is to have the spa room closed and locked and hazardous substances are to be kept inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous chemicals are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On September 23, 2014 at 1619 on the South Wing outside the staff room, two medication packages were noted on top of an unattended medication cart.

A Registered Practical Nurse identified the two medication packages as being Warfarin 1mg and Warfarin 2mg and that the medication packages had been removed from the emergency supply, and left on the top of the medication cart unattended. The Registered Practical Nurse confirmed the expectation of the home is to have all drugs secured and locked. [s. 129. (1)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids prepared, stored, and served are using methods which prevent adulteration, contamination and food borne-illness.

During the initial tour on September 23, 2014 in the Poplar Dining Room it was noted that a tray of desserts consisting of puddings and apple slices were covered with parchment paper and another tray which allowed perimeter desserts to be uncovered.

The Administrator verified that the tray of desserts was improperly covered and had the potential for desserts to become contaminated.
The Administrator confirmed the expectation of the home is to ensure that all food and fluids are stored, using methods which prevent adulteration, contamination and food borne-illness. [s. 72. (3) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An unlabeled urine hat was found in a communal washroom.
A Registered Nurse verified the urine hat was unlabeled and confirmed the expectation of the home was to ensure that all resident items are clearly labeled especially in a shared space. [s. 229. (4)]

Issued on this 9th day of October, 2014

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