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
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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
Apr 30, 2014	2014_255516_0013	L-000386-14	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4

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

ROCHELLE SPICER (516), MARIAN MACDONALD (137), RAE MARTIN (515)

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): April 01 - 04 and April 07 - 10, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, RAI Co-ordinator, Staff Educator, Food Service Supervisor, Registered Dietitian, two Dietary Aides, Resident and Family Services Co-ordinator, Restorative Care Co-ordinator, Registered Physiotherapist, Life Enrichment Co-ordinator, Medical Director, Volunteer Services Co-ordinator, Pharmacist, Office Manager, Environmental Services Supervisor, three Housekeeping Aides, twenty Personal Support Workers, eight Registered Practical Nurses, five Registered Nurses, forty one residents and four family members.

During the course of the inspection, the inspector(s) conducted a tour of all resident home, dining and common areas, medication storage areas and treatment carts. The Inspectors observed resident care provisions, resident-staff interactions, dining service, snack service and recreational activities. Relevant resident clinical records, home policies, procedures and meeting minutes were reviewed. Posting of required information was confirmed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the residents' right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs as evidenced by:

On April 2, 2014, a resident was observed seated in a wheelchair, at the dining room table, and the resident's continent care product was visible.

On April 7, 2014, four residents were observed seated in their respective wheelchairs, at the dining room tables, and the residents' continent care products were visible.

The Director of Care and Staff Educator confirmed the residents' continent care products were visible and the expectation is the residents' right to be properly clothed, and cared for in a manner consistent with their needs will be fully respected and promoted. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted specifically related to ensuring every resident is properly clothed in a manner consistent with his or her needs, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident as evidenced by:

The review of a resident health care record related to vision revealed the information documented in the residents plan of care and kardex were not consistent and did not set out clear direction to staff. This was confirmed by two registered staff members. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home policy for "Medication Management System – Drug Storage" states:

"All drugs and biologicals shall be stored under proper conditions of sanitation,

temperature, light, humidity and security".

The home did not comply with this policy in relation to sanitation as evidenced by:

On April 08, 2014, drug and biological storage observations were completed in the Elgin medication storage room with the Director of Care present. The Director of Care confirmed the following observations did not comply with the homes policy and expectations related to sanitary storage of drugs and biologicals:

The fridge designated for the storage of medications requiring refrigeration contained a glass of thickened juice with a label dated March 24, 2014. The treatment cart designated for the storage of topical medications, bowel care medications and skin and wound care supplies was observed to contain open, used containers of infazinc, petroleum jelly and barriere cream which were not labeled with resident names. The Director of Care confirmed these topical creams should be labeled with a resident name. Staff belongings including purses and coats were being stored in the medication storage room. The Director of Care confirmed staff belongings should not be stored in the medication room and that the home has a designated area for staff to store their personal belongings.

The fridge designated for the storage of biological samples for Life Labs, contained a bottle of water and a bottle of juice. The Director of Care confirmed this fridge is designated for lab samples only and that there is a fridge available for storage of non biological items.

On April 08, 2014, drug and biological storage observations were completed in the Kent medication storage room with the Director of Care and Assistant Director of Care present. The Director of Care and Assistant Director of Care confirmed the following observations did not comply with the homes policy and expectations related to sanitary storage of drugs and biologicals:

The fridge designated for the storage of medications requiring refrigeration contained medications along with several food items and was not being kept in neat order. The Director of Care and Assistant Director of Care confirmed food items should not be stored in the designated medication fridge and that there is an alternate fridge to store food items. Also, the expectation is that items in the medication fridge should be stored neatly.

The treatment cart used for storage of topical medications, bowel care medications and skin and wound care supplies was observed to contain two bottles of sterile water which expired April 01, 2014 and a plastic baggie of pop can tabs. The Director of Care and Assistant Director of Care confirmed the expired sterile water and pop can tabs should not be in the treatment cart. Staff belongings including purses, jackets and lunches were being stored in the medication room. The Director of Care and Assistant Director of Care confirmed staff belongings should not be stored in the medication room and that the home has a designated area for staff to store their personal belongings. [s. 8. (1)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with as evidenced by:

A review of the Falls Prevention and Management Program/Policy, dated Sept 16, 2013 states:

"Registered staff will ensure that, a resident who has a fall, has follow up progress notes completed for at least three shifts following the incident."

A resident sustained a fall and a review of the resident's progress notes revealed the first entry for post fall documentation was not completed per the home policy.

On April 9, 2014, during an interview with the Director of Care and Assistant Director of Care, both confirmed there was no post fall documentation for the next three shifts post-fall and the home's policy was not complied with. The homes expectation is that the Falls Prevention and Management Policy will be complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with as evidenced by:

A review of the Falls Prevention and Management - Program, effective September 16, 2013 indicates:

(a) Physiotherapy will ensure that all residents are assessed for falls risk through transfer/mobility assessment, RAI-MDS completion on admission, quarterly and with significant change in condition.

There was no documented evidence that the assessments were completed quarterly. A review of the resident's clinical record revealed a physiotherapy assessment was completed September 3, 2013 and the quarterly assessment was completed five months later on February 13, 2014. The assessments observed were incomplete.

The Restorative Care Coordinator confirmed the physiotherapy assessments were not completed quarterly, were incomplete and the policy was not complied with. The homes expectation is that physiotherapy assessments be completed quarterly, in detail, per the home's policy.

(b) When a resident has fallen, registered staff will ensure that:

- the resident is the subject of an immediate post fall huddle for completion of the post fall work sheet including possible interventions
- the results of the post fall worksheet are included in the fall incident note
- the incident note is printed and attached to the completed risk form
- follow up progress notes are completed for at least three shifts following incident

A review of the resident's clinical record revealed there was no documented evidence that registered staff completed these tasks.

The Director of Care and Staff Educator confirmed there was no documented evidence that registered staff conducted an immediate post fall huddle or, that the results of the post fall worksheet were included in the fall incident note or, that the incident note was printed and attached to the completed risk form or, that follow up progress notes were completed for at least three shifts following incident. The Director of Care and Staff Educator verified the expectation is that the home's policy related to Falls Prevention and Management is to be complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all drugs and biologicals are stored under proper conditions of sanitation per the homes "Medication Management System - Drug Storage" policy and to ensure the homes Falls Prevention and Management Program/Policy is followed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Observations, throughout the Resident Quality Inspection, revealed:

Paint scrapes, chipped paint, damaged bedroom and bathroom doors/door frames/baseboards, wall damage, damaged ceiling areas, damaged cupboards, damage to wood on dining room chairs, one rusted faucet, one chipped and rusted sink basin, build-up of calcium/lime around faucets, stained toilet bowls, missing toilet bolt caps, caulking required around toilets, five cracked and damaged floor tiles, one radiator pulled away from the wall with screws visible and one radiator cover not secured, a chandelier missing from bottom of mounting rod and dried grease/oil from door hinge closure behind medication room door.

During a tour of the home on April 9, 2014, the Environmental Services Supervisor confirmed the above identified deficiencies and that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. The Environmental Services Supervisor shared the homes expectation is to develop and implement a scheduled plan to correct any identified deficiencies. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there is an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury as evidenced by:

A review of the Falls Prevention and Management - Program indicates the purpose is to provide an interdisciplinary program to reduce the incidence of resident falls and the risk of injury related to the same, as well as, the Falls Prevention and Management - Falls Committee - Terms of Reference - Effective September 16, 2013 indicates membership will consist of:

Physiotherapist Co-Chair
Restorative Care Coordinator Co-Chair
Director of Resident Care or Co-Director of Care or delegate
Education Coordinator
Life Enrichment Coordinator
Registered Staff Member
Personal Support Worker Staff Member
Advisory Physician as required
Community Resources as required

A review of the Falls and Restraints Committee meeting minutes revealed attendance at the meetings as follows:

January 16, 2014 - Restorative Care Coordinator and Physiotherapy Assistant
February 2014 - Restorative Care Coordinator and Physiotherapy Assistant
March 20, 2014 - Restorative Care Coordinator, Physiotherapy Assistant, Physiotherapist and Administrator

There was no documented evidence that the program is interdisciplinary.

The Director of Care confirmed the Falls Prevention and Management Program is not interdisciplinary and the expectation is that program membership and attendance at meetings is to be interdisciplinary. [s. 48. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is interdisciplinary membership and attendance during the homes Falls Prevention and Management Program meetings, to be implemented voluntarily.

WN #6: 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 failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

There was no evidence to verify that a resident exhibiting altered skin integrity was assessed by a member of the registered nursing staff using the homes clinically appropriate skin and wound assessment tool. The Director of Care and Assistant Director of Care confirmed the resident was not assessed. [s. 50. (2) (b) (i)]

2. The Licensee failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A resident had been exhibiting altered skin integrity. It was determined and verified by the Assistant Director of Care and Director of Care that weekly wound assessments by a registered staff member should have been completed for this resident. Review of the residents' clinical record indicates there was no evidence of weekly wound assessments being completed while the resident was experiencing altered skin integrity. The Assistant Director of Care and Director of Care confirmed that weekly wound assessments using the homes clinically appropriate skin and wound instrument were not completed by a registered staff member. [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 the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers,skin tears or wounds receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is designed for skin and wound assessment and that the resident is reassessed at least weekly, using a clinically appropriate assessment instrument by a member of the registered nursing staff, to be implemented voluntarily.

WN #7: 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 at the home were kept inaccessible to residents at all times as evidenced by:

On April 01, 2014, a key was observed to be left in the door to the soiled utility room and access to the room containing hazardous substances was gained. A Personal Support Worker confirmed the key should not have been left in the door and removed it.

On April 07, 2014, the Environmental Services Supervisor confirmed the expectation is that staff keep doors to soiled utility rooms locked 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 substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management as evidenced by:

A review of the online education records, related to Preventing Slips, Trips and Falls for Canada, revealed only 32/158 staff (20%) completed training in falls prevention and management.

The Director of Care confirmed that 80% of direct care staff were not provided training in falls prevention and management and the expectation is that all direct care staff complete the training. [s. 221. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all direct care staff are provided with training in falls prevention and management, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control Program as evidenced by:

A review of the Infection Prevention and Control Program indicates the purpose of the committee is to be responsible to review infection prevention and control activities within the home. Additionally, the Infection Prevention and Control Committee

Meeting - Terms of Reference - effective September 16, 2013, indicates membership will consist of:

Lead for Infection Prevention and Control (Chairperson)
Medical Officer of Health or delegate
Medical Director
Environmental Services Manager
Food Services Manager
Director of Care
Administrator
Occupational Health and Safety Representative
Pharmacist
Front line staff

A review of the Infection Prevention and Control Committee meeting minutes revealed the attendance at the meetings was as follows:

February 13, 2013 - Assistant Director of Care (chairperson) and one Registered Staff member
March 13, 2013 - Assistant Director of Care (chairperson) and RAI Co-Ordinator/Staff Educator
June 20, 2013 - Assistant Director of Care (chairperson), Registered Practical Nurse and two housekeeping staff
December 30, 2013 - Assistant Director of Care(chairperson)

There was no documented evidence that the program is interdisciplinary.

On April 09, 2014 during an interview with the Director of Care and the Assistant Director of Care, it was confirmed that the Infection Prevention and Control Committee was not interdisciplinary and the expectation is that there is an interdisciplinary team approach. [s. 229. (2) (a)]

2. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program as evidenced by:

The following infection control risks were observed throughout the Resident Quality Inspection:

An infection control cart observed in the Oxford home area hallway was visibly soiled with dust and a white powder substance. (515)
[redacted] shared bathroom contained a raised toilet seat sitting on the floor under the sink. (515)
Two resident walkers had visibly soiled seat cushions. (515)

The following room observations revealed personal care supplies without a resident name on them in shared bathrooms:

[redacted] three wash basins (515)
[redacted] one toothbrush and two wash basins (515)
[redacted] two bottles of antiseptic oral care rinse, one tube of toothpaste and one toothbrush (516)
[redacted] two denture cups, one toothbrush with an illegible name and one kidney basin (516)
[redacted] one denture cup (516)
[redacted] one denture cup, one tube of toothpaste and two toothbrushes (516)

On April 9, 2014 an interview with the Director of Care and Assistant Director of Care confirmed the expectation is that personal care items are to be labeled with the resident's name and wash basins that remain in the rooms are to be labeled with the resident's name or removed and cleaned after use. [s. 229. (4)]

3. On April 08, 2014, two glucometers that were located in the medication drawer area had illegible resident name labels on them.

The Director of Care confirmed these glucometers should have legible resident name labels per the homes established infection prevention and control practices. [s. 229. (4)]

4. On April 08, 2014, observations of the Elgin treatment cart were completed with the Director of Care present. Topical medications were being stored in the same drawer as wound care dressing supplies. The Director of Care confirmed these items should be stored in separate drawers per the homes established infection control practices.

On April 08, 2014, observations of the Kent home area treatment cart were completed with the Director of Care and Assistant Director of Care present. Topical medications were noted to be stored in the same drawer as wound care supplies. The Director of

Care and Assistant Director of Care confirmed these items should be stored in separate drawers per the homes established infection control practices. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is an interdisciplinary team approach in the co-ordination and implementation of the Infection and Prevention Control Program specifically related to the Infection Prevention and Control Committee and to ensure all staff participate in the implementation of the Infection Prevention and Control Program specifically related to ensuring all personal care supplies are labeled with the resident's name and kept in sanitary condition and that topical medications and wound care supplies are stored in separate areas within the treatment carts, to be implemented voluntarily.

WN #10: 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 has a screen and cannot be opened more than 15 centimeters as evidenced by:

On April 1, 2014 at 09:00, two/nine windows observed in the Oxford-Elgin dining room and one/ten windows observed in the Oxford TV room opened to 35cm.

On April 2, 2014, the Administrator confirmed these windows opened to 35cm and this presented a safety risk for residents. [s. 16.]

WN #11: 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 resident-staff communication and response system could be easily seen, accessed and used by residents, staff and visitors at all times as evidenced by:

On April 1, 2014, a resident bathroom call bell was observed to be tied to the grab bar and located behind the toilet tank. The call bell was not easily seen or accessible to the residents. This was confirmed by a Personal Support Worker.

On April 2, 2014, two resident call bells were observed to be on the floor beside the head of the bed. A Personal Support Worker confirmed the call bells were not accessible to the residents.

On April 01,2014 the Administrator confirmed the expectation is that all call bells should be easily seen and accessible by residents, staff and visitors at all times. [s. 17. (1) (a)]

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 did not ensure that drugs a stored in an area or medication cart complied with manufacturer's instructions for the storage of the drugs, specifically in relation to expiration dates.

On April 08, 2014, a prescribed topical medication which had expired, was observed to be in the treatment cart. The Assistant Director of Care verified this medication had expired and should not be in the treatment cart and removed same. [s. 129. (1) (a)]

Issued on this 16th day of May, 2014

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