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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2014	2014_211106_0006	S-000050-14	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive, KENORA, ON, P9N-2W7

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

NORTHWOOD LODGE
51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0

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

MARGOT BURNS-PROUTY (106), LAUREN TENHUNEN (196)

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): February 18, 19, 20, 21, 25, 26, 27, 2014

The following Logs were reviewed as part of this inspection: Log# S-000050-14, S-000048-14, S-000471-13

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), Dietary Aides (DA), Environmental Services Manager (ESM), Activity Aide, Family Members and Residents

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Quality Improvement
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation
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. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The health care record for resident #7317 was reviewed by the inspector on February 25, 2014. The demographic sheet at the front of the resident's hard copy of chart lists as part of the diet, a specific supplement twice daily (BID). The "Quarterly Nutrition Review" completed by the Registered Dietitian (RD) on Oct. 8, 2013, identifies the specific supplement was discontinued. These two pieces of the resident's plan of care have conflicting information about the specific supplement's use. The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The "Northwood Resident Information" sheet found in resident #7317's washroom noted the resident was on a "regular, minced diet". The care plan with last update of Jan. 16, 2014, identified under the focus of "nutritional care" the resident was on a puree texture diet as did the quarterly medication review document. The licensee

failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. A RAI MDS assessment for resident #7317, was reviewed by the inspector. In section C, Communication/Hearing Patterns, the RAI MDS assessment indicated that no communication devices/techniques are used by this resident.

The Care Plan document for resident #7317 was reviewed, which indicated, "HCA ensures hearing aid is functioning and in place-currently have to have ears tested for new hearing aids" and that glasses and hearing aids are normally used by resident

2 PSWs and 1 RPN were interviewed by the inspector regarding the use of resident #7317's hearing aids and all told the inspector that the resident does not have hearing aids, nor could they remember the resident ever having hearing aids. On February 26, 2014, the inspector had a short conversation with resident #7317 and observed that they did not have hearing aids in situ at that time.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

4. An interview conducted with staff member #S-104 on Feb. 25, 2014, at 1800 hrs, and they identified to the inspector, that the residents listed on the form titled "Residents requiring additional nutritional support - Resource 2.0 at Medication Pass (Updated February 2014)" did not receive their 1700hrs scheduled supplement. This included residents #7292, 7305, 7308, 7317, 7290, and 7320. Staff member S-104 told the inspector that the dietary staff provide the Resource 2.0 to the residents and that the registered staff sign that it was given. According to an interview with dietary staff member #S-105, the nurses give the Resource 2.0 not the dietary staff.

On February 25, 2014, registered staff member confirmed to the inspector that residents #7292, 7305, 7308, 7317, 7290, 7320 did not receive their Resource 2.0 as ordered as they thought the dietary staff gave it to the residents. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

5. The document titled, "Northwood Lodge Nutritional Supplement RX as per Dietitian

(updated Feb. 2014)" was copied, by the inspector. It noted the breakfast, lunch, and supper provisions of prune juice, ground flax, Boost 1.5, Boost juice, Diabetic Resource and Boost pudding and the residents' names accordingly, it also contained the following, "NOTE - All Resource 2.0 will now be a medication pass and signed off when given by the RN or RPN" [s. 6. (7)]

6. The health care record for resident #7290 was reviewed for information regarding nutritional needs. The care plan with last update of January 22, 2014, including the focus of "nutritional care", identified the resident as high nutritional risk, choke risk and included the interventions of a supplement three times per day (TID) and an additional supplement ordered at pm and hs snack and that the resident "should not be left alone while eating/drinking".

The afternoon nourishment pass on February 26, 2014, was observed by the inspector and resident #7290 was seen with a glass of thickened juice in their hand, alone in their room. An interview was subsequently conducted with a PSW and it was reported that a snack had not been provided during this afternoon nourishment pass and that resident #7290 could be left alone drinking fluids as they weren't a risk.

The inspector observed the beverages that had been placed in front of resident #7290 for dinner service on Feb. 25, 2014, and no supplement was served to the resident. Beverages observed to be provided to resident #7290, included coffee, cranberry juice and water. An interview was conducted with dietary staff member S-105 and it was reported to the inspector that the nurses are to administer specific supplements to the residents.

At 1845hrs on February 25, 2014, registered staff member confirmed to the inspector that resident #7290 did not receive their supplement as ordered as they thought the dietary staff gave it to the residents.

On February 25, 2014, resident #7290 was not provided with the nutritional supplement and on February 26, 2014, they were left alone in their room drinking fluids and not provided with a snack during the afternoon nourishment pass, specifically the additional supplement.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

7. The health care records for resident #7317 were reviewed by the inspector on February 25, 2014. The "Quarterly Nutrition Review" completed by RD on January 16, 2014, included a "plan of action" to change a supplement to twice daily (BID) from four times daily (QID).

The care plan with the last update of January 16, 2014, included the use of the nutritional supplement BID. The Medication Administration Record (MAR) identifies that the resident has been receiving the supplement QID in February 2014, specifically, Feb. 1 through to 24th. Resident #7317's plan of care identified a change in the frequency of administration of the supplement from four times daily to twice daily, yet this was not provided to the resident.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

8. The health care record for resident #7303 relating to nutrition, was reviewed by the inspector on February 25, 2014. The dietary sheet found in the dining room servery included instructions to offer a specific juice at meals to resident #7303.

On Feb. 25, 2014, at 1845hrs an interview was conducted with dietary staff member #S-105 and this staff member told the inspector that resident #7303 was not provided with the specific juice and instead was given another juice because the ordered juice has texture and pulp and that this was not good for the resident. The staff member also stated there was no way to strain this (the pulp and texture) out of the juice.

An interview was conducted on February 26, 2014, at 1750hrs, with dietary staff member S-106, regarding the beverages given to resident #7303 during dinner service. Staff member #S-106 reported that the specific juice was not provided and another juice was given instead. The dietary list was reviewed with staff member #S-106 and it was determined that they were not aware of that a specific juice was to be provided to resident #7303 at each meal. Resident #7303 was not provided on Feb. 25 and 26th, 2014, during dinner service, the specific juice as noted in the resident's plan of care.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

9. On February 27, 2014, at 1130hrs, resident #7303 was observed lying in bed with

bilateral 3/4 side rails elevated. Staff member #S-107 confirmed to the inspector that the resident's bed was not in the lowest position, but that the bed alarm was working.

The care plan for resident #7303 was reviewed, with last update of Jan. 15, 2014. Under the focus of "risk of injury from falls", it identified, the intervention of "HCA ensures bed in lowest position". The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

10. The health care record for resident #7290 was reviewed by the inspector on February 25, 2014. The care plan with focus of "nutritional care" with last update of January 22, 2014, identified the resident as a "high" nutritional risk and included "choking risk" and "(resident) should not be left alone while eating/drinking".

An interview was conducted with staff member #S-103 on Feb. 26, 2014 at 1610hrs and it was reported that the resident was given juice at the afternoon nourishment pass. Staff member # S-103 was then questioned if the resident could be left alone drinking fluids and how would staff know which residents were at high risk? It was reported that resident #7290 could be left alone as they were not a risk and they were unsure of where to find that information about the resident.

The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, specifically in regards to the nutritional care for resident #7317 and that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, specifically in regards to monitoring resident #7290 during the snack service, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On February 24, 2014, resident # 7284's progress notes were reviewed which indicated that the resident was transferred to hospital due to a wound infection; this was later confirmed during an interview with the Administrator/DOC.

The progress notes for January and February 2014 were reviewed and there were multiple entries that indicated that dressing changes to resident #7284 wounds were completed. No wound assessments regarding the wounds were found in the progress notes.

On February 27, 2014, a RPN told the inspector that staff document impaired skin integrity in the progress notes under the focus of skin integrity or in a Progress Note-Wound Assessment (PN-WA). On March 5, 2014 the Administrator/DOC confirmed that the staff had not completed assessments using the PN-WA, which is a clinically appropriate wound assessment instrument that, is specifically designed for skin and wound assessment, used by registered staff.

The licensee failed to ensure that a 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 specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On February 27, 2014, at approximately 1530 hrs during the afternoon snack pass the inspector asked the PSW who was giving snacks and beverages to the residents, if there was a document that they refer to which identifies, the type of diet or supplements the residents are to receive. The PSW stated they did not have anything like that.

The inspector asked the same PSW how they determine which residents receive the Boost and Boost puddings that are on the cart. The PSW told the inspector that that they give the Boost to whoever they feel needs one, for example, if the resident did not eat well at lunch they would give them a Boost.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

2. On February 26, 2014 at 1525hrs, the inspector observed the afternoon nourishment pass and noted a list on the nourishment cart with resident room numbers and names on it and no other information. According to staff member #S-103, staff are aware of the residents and do not need a list on the snack cart to identify residents' diets.

On February 26, 2014, staff member S-103 told the inspector that resident #7313 was given 240mls of fluid and a jug of water during the afternoon nourishment pass. Staff member #S-103 was questioned if they were aware of any residents that were on fluid restrictions and they stated they were unaware of any. The dietary list found in the servery, for the month of February 2014, identified resident #7313 as being on a fluid restriction.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2). O. Reg. 79/10, s. 47 (1).

Findings/Faits saillants :

1. On February 25, 2014, during an interview the Administrator/DOC told the inspector that staff member #S-111, who was hired in 2011, is enrolled in a PSW course, but has not completed the PSW program, nor were they currently enrolled in a nursing program or completing the practical experience requirements of their PSW course.

During this interview the Administrator/DOC also told the inspector that staff member # S-111 had a part time PSW rotation. On February 20, 2014, the Office Manager provided the inspector with the staffing schedules from February 3 to March 2, 2014, during this time staff member #S-111 was scheduled to work as a PSW on 8 shifts.

On February 18, 2014, the inspector observed staff member #S-111, working as a PSW, feed residents during the supper meal service. The licensee failed to ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2). [s. 47. (1)]

2. A voluntary Plan of Correction (VPC) was issued in inspection # 2013_211106_0042 on January 14, 2014, for non-compliance regarding, O. Reg. 79/10, s. 47 (1) and staff member S-111 was identified in that VPC.

Previous Compliance Orders (CO) were issued regarding LTCHA s. 73: "Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72, (a) have the proper skills and qualifications to perform their duties; and (b) possess the qualifications provided for in the regulations".

-CO#902 related to LTCHA s. 73, was issued January 27, 2012, in inspection # 2011_104196_0011 and staff member #S-111 was identified in the order.
-CO#002 related to LTCHA s. 73, was issued September 17, 2012, in inspection#2012_051106_0019 and staff member # S-111 was identified in the order.

-CO#002 was complied, during the follow-up inspection #2013_211106_0031. During that inspection, inspector 106 interviewed staff member #S-111 in August 2013 and they reported that they were working in a temporary position in another department and did not intend to return to work in the home as a PSW after the temporary position ended.

The licensee failed to ensure that on or after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2). [s. 47. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. On February 18, 2014, the housekeeping door opposite the nursing station was ajar slightly and unlocked. The room contained cleaners titled "Enviro Solutions - 70C - general cleaner concentrate", and "Neutral floor cleaner 84C concentrate". According to PSW staff member S-108, the key has broken off in the lock and the maintenance staff were made aware of it.

The licensee failed to ensure that the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, specifically in regards to the housekeeping door opposite nursing station., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. On February 18, 2014 at 1715hrs, the inspector observed dinner service to residents in the home. Upon inquiry, dietary staff member S-106, reported to the inspector that those residents requiring a minced texture diet are provided with hand cut up food. An interview was conducted with the Registered Dietitian (RD) on Feb. 27, 2014, and it was determined that minced texture should be mechanically processed to a texture similar to cooked ground beef and that this concern with the minced texture had been brought forward to management in the past without change. Residents that have been assessed and identified on the dietary list as requiring a minced texture diet are not being provided with it and instead are provided with a cut up texture.

Without restricting the generality of subsection (1), the licensee failed to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

2. Resident #7309 was observed on Feb. 18, 2014, to receive the pork cutlette that had been cut up by hand into approximately 1cm cubes by the dietary staff member. This resident was to receive a minced texture diet as per the dietary sheet and the note from the dietitian dated February 2014. Without restricting the generality of subsection (1), the licensee failed to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, specifically in regards to residents that have been assessed as requiring a minced texture diet, to be implemented voluntarily.

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. On February 19, 2014, inspector #196 observed a chair in resident #7305's room to be soiled with dry green/yellow stains. On February 26, 2014, at 1530hrs, the inspector observed that the chair remained soiled.

The licensee failed to ensure that, the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. Inspector #196 observed the flooring beside the bed in a resident's room, to have a previous repair and pieces of flooring missing around this area. In a resident's room, the flooring around the base of the front of the toilet is missing and pieces are lifting and stained around the remainder of the toilet base.

There was a lingering odour of urine in a resident washroom noted on February 24th and 25th by the inspector. This lingering odour was then confirmed by the housekeeping staff member S-110 on February 25, 2014.

In a resident room, pieces of flooring near the end of the resident's bed was gouged and missing. In addition, the flooring in the corridor outside the servery, at the entrance to the common dining room was missing pieces and gouged.

An interview was conducted on February 25, 2014 with S-102, lead maintenance for the home. The inspector and staff member S-102 conducted a walk thru of those areas where the flooring was in disrepair and it was reported to the inspector that "there is no money in the budget, and it cost a lot of money to replace the flooring" and "these floors are original to the home".

The licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [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 that, the home, furnishings and equipment are kept clean and sanitary, specifically in regards to the chair in resident #7305's room and that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically in regards to flooring that is in disrepair through out the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. On February 20, 2014, during Stage 1 resident interviews, resident #7311 told the inspector that they miss the walking program and wish that it would start up again. Inspector reviewed resident #7311 care plan document, which indicated that the resident is to be walked weekly as tolerated as part of the rehabilitation walking program.

On February 27, 2014, the Administrator/DOC told the inspector that they currently do not have staff to provide restorative care and that the physiotherapist is only on site in the home once per quarter to assess residents. The licensee failed to ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include, on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs. [s. 59. (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 therapy services for residents of the home are arranged or provided under section 9 of the Act that include, on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The health care record for resident #7290 was reviewed by the inspector and identified that the resident's weight was not recorded for the months of November 2013, December 2013 and January 2014. The nutritional care plan with last update of January 22, 2014, identified the resident as being "high risk" nutritionally and included the intervention of eating assistance of one staff and use of nutritional supplements and "HCA weighs (resident) on admission and monthly". An interview was conducted with the RD and it was reported that monthly weights are not being done consistently.

The licensee failed to ensure that the programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter. [s. 68. (2) (e) (i)]

2. The health care record for resident #7317 was reviewed by the inspector and identified that the resident's weight was not recorded for the months of August, November and December 2013. The nutritional care plan with last update of January 16, 2014, identified the resident as being "moderate to high risk" nutritionally and included the intervention of "HCA weighs (resident #7317) during first week of the month during (resident #7317) bath". On February 27, 2014, an interview was conducted by the inspector with the RD and it was reported that monthly weights are not being done consistently.

The licensee failed to ensure that the programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter. [s. 68. (2) (e) (i)]

3. The health care record for resident #7303 was reviewed by the inspector and identified that the resident's weight was not recorded for the months of November 2013, December 2013 and January 2014.

The care plan with last update of December 3, 2013, identified the resident as "moderate to high risk" nutritionally and included the intervention of "HCA weighs (resident #7303) during first week of the month during (resident #7303) bath". An interview was conducted with the RD and it was reported that monthly weights are not being done consistently.

The licensee failed to ensure that the programs include, a weight monitoring system to measure and record with respect to each resident [s. 68. (2) (e) (i)]

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 Nutrition and Hydration programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. During the afternoon nourishment pass on February 26, 2014, staff member #S-103 reported to the inspector that resident #7290 was provided with juice but no snack. Staff member #S-103 also stated to the inspector that there was "hardly enough time to do the snack pass" and "not enough staff".

The "food and nourishment daily record" for February 2014 for resident #7290 was reviewed and over the course of 25 days, there was no documentation to identify the resident getting any afternoon nourishment on 19 days. The care plan for resident #7290 with last update of January 22, 2014, identified the resident as "high risk" nutritionally.

The licensee shall ensure that each resident is offered a minimum of, a snack in the afternoon and evening. [s. 71. (3) (c)]

2. On February 27, 2014, the inspector spoke to the Administrator/DOC and dietary staff member #S-105 regarding the menu items that were on the afternoon snack cart. Both staff members reported that a menu is not followed for the afternoon snack. Both the Administrator/DOC and the DA indicated that a fruit item and cookie/muffin are usually on the cart.

On February 27, 2014, during a phone interview the home's RD reported that they had prepared a menu for the afternoon snack and it had been shared with the home's management team as well as the person who orders the food for the home. On March 3, 2014, the RD provided a copy of the home's "Nourishment Rotation - Northwood Lodge" for 4 weeks.

The licensee failed to ensure that the planned menu items are offered and available at each meal and snack. [s. 71. (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 each resident is offered a minimum of, a snack in the afternoon and evening, specifically in regards to resident #7290 and to ensure that the planned menu items are offered and available at each meal and snack, specifically in regards to the afternoon snack service, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. On February 18, 19, 20, 2014, resident #7284 was observed in their wheelchair with a restraint applied. The care plan document was reviewed and it indicated, that the registered staff member is to reassess need for restraint q1h as per the home's policy and standards. Policy # NUR 400, "Restraint & PASD Use", was reviewed, which indicated, "The registrant assesses comfort and safety of resident hourly and documents on form".

The "Northwood Lodge Hourly Monitoring Record" from Feb. 1 to 24, 2014, was reviewed and it was found that registered staff did not document on the form to indicate they had assessed the need for the resident to be restrained, at least every 8 hours:
Nights: Feb 1, 2, 9, 15, 17, 19, 23, 24, 2014
Days: Feb. 12, 17, 19, 2014
Evenings: Feb. 12, 2014

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

2. On February 18, 19, 20, 24, 25, 26, 2014, resident #7317 was observed in their wheelchair with a restraint applied. The care plan document was reviewed and it indicated, that the registered staff member is to reassess need for restraint q1h as per the home's policy and standards. Policy # NUR 400, "Restraint & PASD Use", was reviewed and it indicated, "The registrant assesses comfort and safety of resident hourly and documents on form".

The "Northwood Lodge Hourly Monitoring Record" from Feb. 1 to 24, 2014, was reviewed and it was found that registered staff did not document on the form to indicate they had assessed the need for the resident to be restrained, at least every 8 hours:
Nights: Feb 1, 9, 12, 13, 14, 15, 17, 19, 23, 2014
Days: Feb 12, 17, 19, 2014
Evenings: Feb 12, 2014

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2)

6.]

3. On February 18, 19, 20, 2014, resident #7284 was observed in their wheelchair with a restraint applied. The care plan document was reviewed and it indicated that staff are to assess and document comfort, safety and use of ordered restraint on the "Northwood Lodge Hourly Monitoring Record".

The "Northwood Lodge Hourly Monitoring Record" from Feb. 1 to 24, 2014, reviewed and it was found that staff did not document the resident's response to the restraint on the following shifts:
Days: Feb. 8, 9, 10. 11, 12, 13, 14, 2014.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

4. On February 18, 19, 20, 24, 25, 26, 2014, resident #7317 was observed in their wheelchair with a restraint applied. The care plan document was reviewed and it indicated that staff are to assess and document comfort, safety and use of ordered restraint on the "Northwood Lodge Hourly Monitoring Record".

The "Northwood Lodge Hourly Monitoring Record" from Feb. 1 to 24, 2014, reviewed and it was found that staff did not document the resident's response to the restraint on the following shifts:
Days: Feb. 4, 8, 9, 10, 11, 12, 13, 14, 2014.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

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 following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances and all assessment, reassessment and monitoring, including the resident's response are documtmented, specifically in regards to residents #7284 and 7317, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. On February 25, 2014, at 1020hrs, the inspector reviewed the medication cart and contents, accompanied by registered staff member #S-100. In the top drawer of the cart, several government stock medication bottles were lying on their sides with plastic medication cups filled to the top with pills.

The following medications were in the plastic medication cups:
-Vitamin D,
-Vitamin C,
-Calcium tablets,
-Senokot,
-Vitamin B12,
-Colace,
-Biscodyl,
-ASA 81mg,
-Multivitamins, and
-Tylenol ES tablets.

Registered staff member #S-100 reported that it is "hard to open and close these bottles 32 times per day" and therefore puts them in cups for ease of administration. These medications were put into other containers prior to being administered to residents and were not kept in the original Government of Ontario labelled containers.

The licensee failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

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 remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #13: 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. On Thursday February 27, 2014, the inspector reviewed the contents of the refrigerator in the medication room and noted a plastic bag containing half of an egg salad sandwich.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. During a review of the contents of the medication cart on February 25, 2014, the inspector observed several controlled substances not stored in a separate area within the locked medication cart. Specifically, there was a blister pack for resident #7303 which contained controlled substances and a blister pack for resident #7289 with a controlled substance. Registered staff member #100 reported that these specific medications are not double locked.

In addition, in the top drawer of the medication cart, which is not double locked, the inspector found several containers of a controlled substance for the following residents:
-#7313
-#7323
-#7309
-#7284
-#7292
-#7308
-#5109

According to registered staff member #S-100, these specific controlled substances are not double locked. A medication bottle of another controlled substance in excess of 50 tablets, for resident #7290, was also found in the cart, in a drawer that is not double locked.

In the wall cupboards, which are not double locked, in the medication room, 2 bottles of controlled substances were found.

The licensee failed to ensure that, 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. [s. 129. (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 that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and to ensure that controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate area within the locked medication cart, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. On February 25, 2014, during an interview with the DOC/Administrator, the inspector was shown the annual Infection Prevention and Control program evaluation. It did not include the names of the persons who participated in the program evaluation, a summary of the changes made or the date that those changes were implemented. The licensee failed to ensure that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 229. (2) (e)]

2. On Februrary 18, 2014, during the supper dining service from approximately 1705 hrs to 1800 hrs inspector 106 observed the following:
-a PSW was observed to touch their face multiple times and then serve residents their meals without practicing hand hygiene after touching their face
-the dietary aide was observed to touch their face with the back and side of their gloved hand and then plate residents' meals without changing gloves or practicing hand hygiene, this occurred multiple times during the time the inspector observed the meal service.

The licensee failed to ensure that all staff participate in the implementation of the program. [s. 229. (4)]

3. On Feb 26, 2014, at 1550, the snack cart was observed, by the inspector to have a plate of uncovered cookies and an open multi-serving container of peach yogurt uncovered as it was wheeled down the corridors of the home. At approximately 1550 hrs a PSW was observed to push the snack cart into the TV lounge area, serve multiple residents snacks and beverages and take a muffin out of a plastic container with their hand and place it on a napkin and then serve the muffin to a resident, all without practicing hand hygiene. The licensee failed ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

4. On February 27, 2014, inspector asked staff member #S-112 to show the inspector that TB screening was completed for residents #7317, #8016 and #7286, either 90 days prior to or 14 days after admission. Staff member # S-112 was unable to provide of show the inspector that TB screening had been completed either 90 days prior to admission or 14 day after admission to the home for the before mentioned residents. The licensee failed to ensure that the following immunization and screening measures are in place: 1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some

time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

5. On February 25, 2014, during an interview, the home's Administrator/DOC told the inspector that residents are not offered immunizations against tetanus and diphtheria. The licensee fail to ensure that the following immunization and screening measures are in place: 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 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 following immunization and screening measures are in place to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee and residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On February 26, 2014, at 1720hrs, inspector #196 observed staff member # S-108 sitting at dining table assisting resident #7303 with their supper meal. Staff member #S-108 was observed to use spoon to scrape food off of the resident's chin and proceed to feed the resident. Staff member #S-108 was also observed to scrape pureed food off the clothing protector and chin of resident #7308 and feed to the resident, while assisting with their dinner meal. [s. 3. (1) 1.]

2. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On February 18, 2014, the Spa room was observed to have plastic containers beside the sink that contained an unlabelled hair brush soiled with hair and debris, four unlabeled combs with debris, four used deodorants, all unlabelled.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

2. On Feb 20, 2014, during stage one observations inspector observed in the washroom that is shared by residents #7306 and #7308 there were 5 unlabelled toothbrushes in the cabinet and 2 unlabelled denture cups sitting on the vanity.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items [s. 37. (1) (a)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. On February 21, 2014, the DOC/Administrator provided the inspector with the completed "LTCH Licensee Confirmation Checklist - Quality Improvement". Question #1 "Has the licensee developed and implemented a quality improvement (QI) and utilization review system that monitors, analyzes, evaluates and improved the quality of the care,service, accommodation, programs and goods provided to residents" was answered no.

On February 25, 2014, the inspector clarified this with the Administrator/DOC and they told the inspector there is no Quality Improvement Program currently implemented in the home. The licensee failed to ensure that a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home was developed and implemented in the home. [s. 84.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. An interview was conducted with the Administrator/DOC on February 27, 2014, and it was reported that there is no interdisciplinary team currently, that meets quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 115. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. During a review of the medication room on February 25, 2014, the inspector observed a bottle of Life brand Halibut Liver Oil on the shelf with a note written on it "to call if more is needed" with a contact number. This Life brand bottle was not labelled by the pharmacy service provider and according to registered staff member #S-100, it is being used to refill the pharmacy labelled bottle as found in the medication cart and that family is providing this medication.

The licensee failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. [s. 122. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On February 26, 2014, at 1800hrs, Inspector #196 observed a container of prescription cream on the bedside table in resident #7313's room. An interview was conducted with staff member S-114 on Feb. 26, 2014, and it was determined after a review of the resident's health care record, that there was no current physician's order for this cream.

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 31. (3)	CO #001	2013_211106_0042	106
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2013_211106_0025	106

Issued on this 9th day of May, 2014

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