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**

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

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


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 19, 2015 | 2015_299559_0018 | T-1746-15 | Resident Quality Inspection |

### Licensee/Titulaire de permis

THE DISTRICT OF THE MUNICIPALITY OF MUSKOKA
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

THE PINES
98 PINE STREET BRACEBRIDGE ON P1L 1N5

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

ANN HENDERSON (559), BARBARA PARISOTTO (558), MATTHEW CHIU (565), VALERIE PIMENTEL (557)

### 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): August 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18 and 19, 2015.**

**During the course of this inspection Critical Incident T-2464-15 and Complaint T-2838-15 were inspected.**

**During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), activities manager, office manager, maintenance, registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), Residents' Council President and Family Council chair, families and residents.**

**During the course of the inspection the inspectors(s) conducted a tour of the home, observed staff interaction with residents, observed the provision of care to residents, observation of medication administration and meal service, reviewed clinical records and relevant policy and procedures related to the inspection.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Sufficient Staffing**

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

**4 WN(s)**
**2 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

On three identified dates, an identified resident stated to the inspector the home is cold when the air conditioning is on and the regulator does not work. A second resident revealed it is cold in his/her room and the air vent had been closed.

Interviews with RPN #108, #109 and PSW #107 revealed they have received complaints indicating the air temperatures as being cold in six resident rooms, an identified hallway and the main floor foyer. RPN #108 further revealed an identified resident had complained on an identified date, regarding cold air temperatures to the RAI coordinator; who reported the concern to the RPN who recorded it into the electronic maintenance tracking system.

An interview with maintenance worker #111 revealed he/she had received the maintenance request.
The RPN and inspector went to the resident's room and observed the resident in bed and the RPN retrieved a heated blanket for the resident.

On an identified date and time, the inspector, maintenance manager and maintenance worker conducted a tour to confirm the temperatures of the identified rooms, hallway and main floor foyer. Staff obtained digital thermometer readings of the air temperatures in the three resident rooms, identified hallway and the main floor hallway and they were below 22 degrees Celsius.

PSW #112 commented to the inspector, office manager and maintenance worker the identified hallway felt colder the day before and it was due to the weather but had failed to report it.

The maintenance manager and maintenance worker confirmed the home was not maintained at a minimum of 22 degrees Celsius in the identified rooms, hallway and main floor foyer. [s. 21.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.***

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**WN #2: 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 failed to ensure that drugs are stored in an area or a medication cart that is secure and locked

On an identified date, on an identified home area during meal service, the inspector observed an unlocked medication cart in the corridor outside the dining room. RPN #113 was in the dining room assisting with meal service. An interview with the RPN revealed the home's practice is to store the medication cart in the medication room during meals. The RPN confirmed she did not follow this practice and proceeded to lock the cart.

An interview with the ADOC confirmed the home's expectation is to have the medication cart locked and stored in the medication room. [s. 129. (1) (a) (ii)]

2. On an identified date, on an identified home area, the inspector observed an unlocked medication cart in the common area outside of the dining room at the opposite end to the dining room servery. RPN #113 was in the dining room at an identified table in front of the servery, administering medications to four residents. The medication cart was not visible at all times to the RPN. The RPN confirmed he/she had not locked the medication cart as the residents have dementia and would not access the medication cart and indicated there was no risk to anyone by not locking the medication cart.

On an identified date, RPN #113 approached the inspector and revealed he/she did lock the medication cart this morning during the medication pass and confirmed the medication cart should be locked at all times.

An interview with the DOC confirmed the home's expectation is the medication carts are to be locked at all times when there are no staff in the immediate area. [s. 129. (1) (a) (ii)]

***Additional Required Actions:***

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

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**WN #3: 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:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act is fully respected.

On an identified date and time,the inspector observed an open computer screen on a medication cart revealing 15 resident names. The cart was located in the corridor outside the dining room of an identified home area. The registered staff was assisting with meal service in the dining room. An interview with RPN #113 demonstrated how to access the residents' medication information from the open screen and lacked awareness this was residents' personal health information. The registered staff indicated the residents on the identified home area would not be capable of accessing the information.

An interview with the ADOC confirmed the home's expectation is to have the computer screen logged off for privacy reasons when not in use. [s. 3. (1) 11.]

2. On an identified date, the inspector observed an open electronic Medication Administration Record (eMAR) on the medication cart when RPN #113 was administering medications in the dining room. An interview with the RPN, confirmed he/she had left the eMAR open with potential accessibility to the health care record of the residents. The RPN demonstrated awareness anyone could access residents' personal health information. RPN #113 indicated the residents on the identified home area would not be capable of accessing the information but acknowledged visitors and volunteers could.

An interview with the DOC confirmed the home's expectation is to have the computer screen logged off for privacy reasons when not in use. [s. 3. (1) 11. iv.]

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**WN #4: 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 is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

The inspector reviewed the following policy: Resident Care Manual, Section: Drug Administration/Utilization, Document Number: 01-13-8, Subject: Medication Pass, Date: January 2011. The home's policy identifies registered staff are not to pre-pour medications for residents.

On an identified date, the inspector observed RPN #113 with four medication administration cups containing medications for four identified residents. The RPN then placed the individual medication cups containing the resident's medication in front of each resident. When the inspector asked RPN #113 if he/she had pre-poured the identified residents medications, his/her response was yes. When the RPN was asked what the home's policy is his/her response was "I don't know I don't read the policies". On an identified date, the inspector reviewed the policy with the RPN and he/she confirmed the home's policy does not allow registered staff to pre-pour medications.

An interview with the DOC, confirmed the registered staff should not pre-pour medications and the home did not ensure the policy was complied with.

The inspector reviewed the following policy: Resident Care Manual, Section: Drug Administration/Utilization, Document Number: 01-13-21, Subject: Medication Carts, Date: January 2011. The home's policy identifies when the registered staff, are not in attendance at the medication cart the cart will be locked and the electronic medication administration record (Emar) application will be logged out.

On an identified date, RPN #113 was observed at an identified table in the dining room, the medication cart was at the opposite end of the dining room in a common lounge area used by residents and visitors. The medication cart was left unlocked and the eMAR application was open for viewing of resident private and confidential information. When the RPN was asked what the home's policy is, his/her response was "I don't know I don't read the policies".

An interview with RPN #113 confirmed that he/she had left the medication cart unlocked and the eMAR application open. The DOC confirmed that the home did not ensure the home's policy was complied with. [s. 8. (1) (b)]

**Issued on this 4th day of November, 2015**

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

**Original report signed by the inspector.**