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
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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 24, 2013	2013_207147_0006	H-000085-13	Resident Quality Inspection

Licensee/Titulaire de permis

LIUNA LOCAL 837 NURSING HOME(HAMILTON) CORPORATION
44 HUGHSON STREET SOUTH, HAMILTON, ON, L8N-2A7

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

QUEEN'S GARDEN
80 Queen Street North, HAMILTON, ON, L8R-3P6

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

LALEH NEWELL (147), MARILYN TONE (167), MICHELLE WARRENER (107)

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 19, 20, 22, 25, 26, 27, 28, March 1, 5, 6, 7 and 8, 2013

H-000085-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Co-ordinator, Registered staff, Personal Support Workers (PSW), Dietitian, Food Service Manager, Dietary aides, Environmental Manager, Recreational Manager, Family and Resident Council Presidents, families and residents.

During the course of the inspection, the inspector(s) completed physical tour of the home, reviewed resident's clinical records, home's policies and procedures, and Resident and Family Council minutes. Observed resident care, medication pass, dining and program activities in the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Death

Infection Prevention and Control

Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

It was observed on several occasions during the inspection period that the dinning room on one of the home areas were unlocked and the barricade to the servery and kitchen was left open and unattended by staff, which allowed the residents access to the hot water, stoves and hot tables. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure resident #654 plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's vision.
Review of the resident's plan of care did not include at a minimum an interdisciplinary assessment related to the resident's vision. The resident's Resident Assessment Protocol (RAP) summary reviewed for the past three quarters did indicate a decline in the resident's vision due to the aging process which now required strategies and interventions to ensure the resident's safety in their surrounding environment. [s. 26. (3) 4.]

2. The plan of care for resident # 675 did not include identification of the use of a seat belt used as a personal assistive service device to prevent the resident from falling when in their wheelchair.
The resident was observed to be wearing a seat belt when they were up in their wheelchair. The resident confirmed that the seat belt was used to prevent them from falling out of the chair. The staff interviewed confirmed that the seat belt was used for safety to prevent falls and that the resident wishes to have it applied.
The document that the home refers to as the care plan did not identify either on the Kardex portion or the narrative portion of the care plan that the resident used a seat belt while in their wheelchair. [s. 26. (3) 19.]

3. The home's registered dietitian did not assess resident #680's nutritional status and all risks related to nutrition care. Progress notes reviewed indicated the resident was having difficulty swallowing and was noted to be coughing. A swallowing assessment and change of current food texture was requested, however, at the dietitian next review an assessment related to the coughing and swallowing difficulties did not occur. Staff confirmed that a referral to the Registered Dietitian or Speech Language Pathologist did not occur after the first episode identifying the initial concerns related to chewing and swallowing. The Registered Dietitian did not re-assess resident #680's nutrition and hydration requirements after a significant change. The Dietitian confirmed that the re-admission nutritional review did not include a re-assessment of the resident's nutritional requirements related to skin integrity, hydration and protein status. [s. 26. (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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Vision and safety risks and to ensure that a registered dietitian who is a member of the staff of the home assesses the matters referred to paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
  i. a physician,
  ii. a registered nurse,
  iii. a registered practical nurse,
  iv. a member of the College of Occupational Therapists of Ontario,
  v. a member of the College of Physiotherapists of Ontario, or
  vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the use of a personal assistance service device (PASD) described in subsection (1) was used to assist resident # 675 with a routine activity of daily living only if the PASD was included in the resident's plan of care. Resident # 675 was observed to be using two bed rails when in bed. The resident confirmed that they used the bed rails to assist them with mobility in bed. Staff interviewed confirmed that the resident uses two bed rails in bed to assist them to turn and position the resident. It was confirmed that the bed rails would be considered a PASD. A review of the most current version of the document that the home refers to as the care plan in the point click care system revealed that there was no mention of side rail usage for the resident. The plan of care for resident # 675 did not include the use of bed rails that were considered to be a PASD. [s. 33. (3)]

2. The licensee did not ensure that the following were satisfied prior to the including the use of two bed rails to assist resident # 675 in routine activities of daily living when in bed.
1) Alternatives to the use of the personal assistance services device (PASD) have been considered
2) The use of the PASD is reasonable
3) The use of the PASD has been approved.

It was noted during a review of the health file for resident # 675 that there was no assessment completed including other alternatives tried prior to the use of bed rails as a PASD for the resident. During an interview with a registered staff member and the Resident Assessment Instrument (RAI) Co-ordinator, it was confirmed that assessments related to alternatives tried are not being completed prior to the use of bed rails as a PASD for residents. During an interview with the Director of Care it was confirmed that the home is currently in the process of implementing the use of the " Ontario Bed Rail Assessment" but this is in the initial stages. It was also confirmed by staff interviewed that consent is not routinely obtained for the use of bed rails as a PASD. (167)

The use of a PASD under subsection (3) to assist a resident with a routine activity of living was used for resident 760 (2 bedrails) without meeting the requirements of subsection (4).
Staff confirmed an assessment of the use of the PASD was not completed prior to the application of the PASD, including consideration of alternatives to the use of the PASD, the approval of the PASD by a physician, registered nurse, registered

practical nurse, member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, and documented consented obtained from the resident for the use of the PASD.

The use of a PASD under subsection (3) to assist a resident with the routine activity of daily living may be included in the resident's plan of care only if alternatives to the use of a PASD have been considered and tried, the use of the PASD is reasonable given the resident's physical and mental condition and consent has been obtained.
Resident # 680 was observed to be using two half bed rails when they were in bed.
- Registered staff and personal support worker staff interviewed confirmed that two bed rails are used for resident # 680 to prevent the resident from rolling out of bed when they are sleeping. Staff members interviewed also confirmed that the resident is able to get out of the bed when the rails are up.
- During interviews with two registered staff, it was noted that they were not aware of the need to complete an assessment prior to use of the bed rails. They were also not aware of the need to obtain consent to the use of bed rails unless the bed rails were considered to be a restraint.
- During an interview with the Director of Care it was confirmed that the home is just in the process of providing education to staff related to the use of bed rails and that staff will now be expected to complete the Ontario Bed Rail Assessment in the electronic documentation system to determine risk prior to the use of bed rails. (167)

The use of a PASD under subsection (3) to assist a resident with a routine activity of living was used for resident 654 (2 bedrails) without meeting the requirements of subsection (4).
Staff confirmed an assessment of the use of the PASD was not completed prior to the application of the PASD, including consideration of alternatives to the use of the PASD, the approval of the PASD by a physician, registered nurse, registered practical nurse, member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, and documented consented obtained from the resident for the use of the PASD. [s. 33. (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 use of a personal assistance service device (PASD) described in subsection (1) was used to assist residents with a routine activity of daily living only if the PASD is included in the resident's plan of care and to ensure the use of a PASD under section (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 1) Alternatives to the use of the personal assistance services device (PASD) have been considered
2) The use of the PASD is reasonable
3) The use of the PASD has been approved., to be implemented voluntarily.

WN #4: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Food was not always served at a temperature that was palatable to the residents. Residents identified concerns with food temperatures at the end of meals during the inspection and when temperatures were taken at the end of the lunch meal service on February 28, 2013, two items were less than 140 degrees Fahrenheit (F) (recipes indicate food must be held at > 140 degrees F). Staff confirmed during interview that food was often cold at the end of the meal. Staff also confirmed that end of meal temperatures were not routinely being recorded by all staff members prior to serving the food. Food temperatures were not taken at the lunch meal in the Westdale home area at the lunch meal March 7, 2013. Resident's Council Meeting minutes also identified concerns with food temperatures. [s. 73. (1) 6.]

2. Proper techniques were not used when assisting resident #654 to eat during the lunch meal. Staff were scraping the resident's mouth quite aggressively with a hard spoon when feeding the resident. [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents and 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to resident #679 in accordance with directions for use specified by the prescriber. The resident had a physician order (identified on the Medication Administration Record) for a dulcolax suppository to be administered after 3 days without a bowel movement, however, this was not followed as prescribed for, on nine different dates.

Staff confirmed the counting of days between bowel movements was correct and that interventions would be provided the morning of the third day. Staff interview identified that the resident did not eat well when they were constipated. [s. 131. (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 drugs are administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participate in the implementation of the infection control and prevention program.

a. A review of the home's policies related to shower and shower/commode cleaning and tub cleaning (LTC Care Staff Guide Book - current version September 2012) that was provided by the Environmental Services Manager indicated that care staff giving a shower or tub bath are responsible for disinfecting the shower or tub after each use. For the shower area the directions included: Utilizing the disinfecting solution dispenser (Retrieve virox from locked closet) and apply to all surfaces of the interior of the shower and shower commode chair including the bottom of the chair, with a cleaning brush, scrub all surfaces of shower and chair. Allow solution to remain for five minutes, then rinse with warm water. Return virox to locked closet and ensure locked, then remove protective equipment and hang up on hook provided, ensure that goggles are cleaned with virox wipes.
For the Tub area the directions included: The staff completing the bath is responsible for disinfecting the tub and tub chair following the bath. Drain the tub and rinse the sides bottom of tub and chair with warm water. Utilizing the disinfecting solution dispenser, apply solution to all surfaces of the interior of the tub and tub chair, including the bottom of the tub chair , scrub all surfaces with cleaning brush, allow to remain for five minutes and then rinse thoroughly.
Posted on the wall in the tub and shower areas the procedure indicates that use of R2A to disinfect the tub and shower areas between each use.
It was noted during a tour of each tub/shower area at the home that none of these areas contained protective equipment for staff to use. During interviews with personal support worker (PSW) staff working on different units of the home, it was noted that disinfectant is not routinely kept in the tub and shower areas of the home. Staff confirmed that they have to go to the "mud room" to obtain the disinfectant. During a review of the "mud rooms" on each home area it was noted that only one "mud room" was found to have a disinfectant present on March 5, 2013 and this disinfectant was labelled as R2A. Only one of the tub /shower areas contained a disinfectant and it was noted to be the wrong disinfectant by PSW # 2.
PSW # 3 indicated that they would use vinegar instead or virox wipes if no disinfectant present.
During an interview with PSW # 5 they indicated that housekeeping cleans and disinfects the tubs and shower chairs. The inspector asked if this disinfecting was done between each shower or bath by housekeeping and they indicated that they did not know. The PSW indicated that nursing does not do the disinfecting after each bath

or shower.
During an interview with a PSW # 6 they indicated that one half of the time they do not have any disinfectant to clean the tub or shower areas so they use peri-wash or body wash.
During an interview with PSW # 7 they confirmed that there is rarely any disinfectant present to clean the tub/ shower areas so housekeeping generally does the cleaning.
During interviews with two housekeepers, it was confirmed that they clean the tub/shower areas once per day and do not clean between each use of the equipment.
The staff at the home are not participating in the home's program related to cleaning and disinfecting of tub and showers. (167)

b. During the noon medication administration on February 28, 2013 on Westdale and Gage Park Home area the registered staff were observed not to utilize hand hygeine practices between administrating medication to the residents. (147) [s. 229. (4)]

2. The licensee did not ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website immunization.

During a review of the health files for five residents admitted to the home over the past six months, it was noted that these residents were not offered pneumococcal vaccine or tetanus and diphtheria vaccine.
- It was noted on the "Consent for Administration of Immunization Agents" form that staff at the home are to complete when a resident is admitted that the areas of the form that address pneumococcal, tetanus and diphtheria vaccine are not being completed and there was no indication as to whether the resident had been offered these vaccines, has already received them or had refused them.
- During an interview with the Director of Care and a registered staff member, it was confirmed that residents are not routinely being offered pneumococcal or tetanus and diphtheria vaccines on admission. [s. 229. (10) 3.]

3. The licensee did not ensure that staff were screened for tuberculosis and other infectious diseases in accordance with evidence-based practices.

During a review of the health files for five newly hired staff at the home, it was noted that two out of five of these staff members did not have current TB testing results on file.

One employee was hired in a specific month in 2012 but the TB testing that was on file indicated that TB testing was last done in 2009.
The second employee was hired in a specific month 2012 and it was noted that the last TB test done was dated in 2010 and indicated a positive result with 13 mm of induration. It was also noted that there was no other screening (chest X-ray) to rule out active disease on file.
This information was confirmed by the Director of Care. [s. 229. (10) 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 all staff participate in the implementation of the infection control and prevention program, to be implemented voluntarily.

WN #7: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The home failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
a. It was observed during noon medication pass that resident's #101 and #102 had their blood sugar completed by the Registered Practical Nurse (RPN) in the dining room in presence of other residents. [s. 3. (1) 8.]

WN #8: 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. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The care set out in the plan of care for resident #679 was not provided to the resident as specified in the plan. The resident had a plan of care directing staff to provide 250ml juice at meals in addition to milk. The resident was not offered milk at the observed lunch meal. Staff confirmed that the resident liked milk and also confirmed that it was not offered at the meal. The Registered Dietitian confirmed that the plan of care directed staff to offer the resident milk with all meals. The resident had numerous referrals related to poor hydration and was at risk for poor hydration. [s. 6. (7)]

2. The licensee did not ensure that the document that the home refers to as the care plan for resident # 680 was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #680 was not reassessed and the plan of care reviewed and revised when the resident's care needs changed in relation to choking concerns identified by the family. Family identified that the resident had incidents of choking and near choking while consuming a minced texture diet. The family suggested reasons why the incident may have occurred, however, the resident's diet was not downgraded to decrease the risk to the resident until an assessment could be completed. Progress notes indicated the family had requested a diet texture downgrade after the choking incidents. Staff confirmed the diet texture was not downgraded. The resident was noted to have difficulty swallowing crushed pills. (107)

The most current care plan for resident # 680 found in the electronic documentation system and in the care plan binder on the unit was not updated when there was a change in the resident's care needs.
- The most current care plan was dated as completed in December 2012.
- The care plan related to dressing directs staff to dress the resident in hospital gown related to recent health change. The resident was noted to be dressed in street clothes. Staff interviewed confirmed that the resident is dressed in street clothes during the day.
- The care plan related to mobility indicated that the resident uses a seat belt when in wheelchair. In February 2013, the resident's seat belt was changed for safety and positioning in the wheelchair. Staff interviewed confirmed that the resident's seat belt was changed to a front fastening seat belt recently and that the resident can not undo this seat belt.
- The resident has had wounds with dressings since January 2013. The resident

requires protective dressings to these areas on an ongoing basis to prevent from more harm. The care plan was not updated to include identification of these wounds or provide interventions to manage it. It was noted that there were dressings in place during the review and staff interviewed confirmed that the resident can cause injury if there is no padding or a dressing to cover them. (167) [s. 6. (10) (b)]

3. The licensee did not ensure that the plan of care for resident # 675 was reviewed and revised when the care set out in the plan was not effective in relation to the goal for weight gain. The resident had been below this goal weight range for two years, without a revision to the goal weight range or a revision to interventions to allow for weight gain. The resident did not have interventions in place to facilitate weight gain and the resident did not consume the lunch meal (by resident choice). Interview with the Dietitian indicated that the resident was happy with their weight and did not want to gain weight, however, during interview the resident stated they had lost weight as a result of dissatisfaction with the food/menus/snacks, skipping lunch due to the food issues, and now weighed considerably less than their previous usual body weight. The Food Service Supervisor and Registered Dietitian confirmed that nutritional interventions had not been revised for over 1 year.

The licensee did not ensure that the plan of care for resident # 680 was reviewed and revised when the care set out in the plan was not effective in relation to the goal for weight gain. The resident had been below this goal weight range for over a year, without a revision to the goal weight range or a revision to interventions to allow for weight gain until significant weight loss occurred in February, 2013. [s. 6. (10) (c)]

WN #9: 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 home failed to ensure that the home was equipped with the resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.
The resident-staff communication and response system could not be easily accessed and used by resident #679. The resident's call system was functioning only intermittently. The inspector pushed the button four (4) times without the system working. Staff were notified of the concern. Several days later the resident's call bell was again pushed several times and noted to be non-functioning. Staff determined at that time that the cord for the call button was not functioning properly and was then replaced. The resident had been alone in their room with the call bell attached to their wheelchair when it was noted that the call bell was not functioning. [s. 17. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The home failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a. The licensee did not ensure that actions taken under the nursing program, including assessments, interventions, and the resident's response to interventions was documented related to two choking incidents that occurred in January 2013. Documentation did not include an assessment of the choking events, including what happened, what the resident choked on, any interventions that may have been provided and the resident's response to the interventions. (107)

b. December 2011 progress notes reviewed for resident #734 indicated that the resident had developed a stage 2 pressure ulcer. The home's policy related to skin and wound (LTCE-CNS-1-1) directed staff to complete weekly wound assessments of residents with stage 2 wounds or greater. A review of the health file for resident # 734 revealed that assessments of the resident's wound were completed three times in December 2011, once in February 2012 and twice in April 2012. The Treatment Administration Records (TARS) for the resident indicated that the resident frequently refused to have the assessment done and these refusals were documented. The documentation on the resident's health file did not indicate that the resident refused the assessment for several treatments between January 2012 to April 2012. It was also noted in the resident's progress notes that the wound had not changed much. There was no further documentation on the resident's health file until July 2012 to indicate that further assessments were completed or when the resident's wound actually healed. A review of the Minimum Data Set assessment completed in July 2012 indicated that the resident's wound was healed. During an interview with a registered staff member it was confirmed that the assessments should have been completed weekly for the resident and that these assessments should be documented on the resident's health file. (167)

c. The licensee did not ensure that the responses to interventions was documented for resident #679 after a change in nutrition interventions.
i) The resident's nutritional supplement was discontinued when nursing staff felt it was affecting the resident's blood sugar levels. After the supplement was discontinued, documentation did not reflect an assessment of the effectiveness of discontinuing the nutritional supplement on the resident's blood sugars. The Dietitian confirmed that an evaluation was not documented.

ii) The plan of care was revised to include additional fluids to be given at meals however, documentation did not reflect an evaluation of the effectiveness of this intervention on the resident's hydration status. According to food and fluid intake documentation, the resident's hydration status did not appear to change after this intervention was implemented. (107)
iii) The resident consistently did not consume food at snack time, however, an assessment of reasons why the resident did not consume their snacks was not documented. The Dietitian confirmed that this information was reviewed, however, not documented.

d.The licensee did not ensure that actions taken with respect to resident #760, including assessments, reassessments and the resident's response to interventions were documented.
i)The Activation program did not ensure that resident #760 had a documented evaluation of the MDS-Coding at minimum quarterly in the resident's clinical health record. Staff confirmed that documentation did not currently include an evaluation of the MDS coding or the resident's response to the Activation interventions.
ii) The Activation program did not ensure that resident #657 had a documented evaluation of the MDS coding at a minimum quarterly in the resident's electronic health record. Staff confirmed that documentation did not currently include an evaluation of the MDS coding or the resident's response to the activation interventions.
iii) The recreation and activation program for resident # 734 did not include a documented evaluation of the (Minimum Data Set) MDS coding at a minimum of quarterly. Staff interviewed confirmed that there had been no documented evaluation of the resident's participation in activities or the resident's response to the activation interventions since that time. (167) [s. 30. (2)]

WN #11: 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. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The home failed to ensure that each resident receives assistance, if required, to use personal aids.
Resident #675 did not receive assistance with putting on their glasses. The resident had a plan of care that required glasses to be worn daily, however, the resident did not have their glasses applied and was positioned in the lounge in front of the television set. Staff confirmed the resident's glasses should have been applied. The resident required extensive assistance with personal care. [s. 37. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The home failed to ensure that the Continence program provided a reassessment instrument related to resident #725 bladder incontinence.
The home's continence care policy LTCE-CNS-B-05 indicated that registered staff are to reassess each resident's continence status using the Ont. - Bladder Continence Assessment in Point Click Care (PCC) on a quarterly basis.
Review of resident #725 electronic health record indicates that the home has not completed a reassessment using a reassessment instrument that is specifically designed for assessment of bladder incontinence. The registered staff confirmed that the reassessments are conducted using the Ont. _Bladder Continence assessment forms in PCC on a quarterly basis, however the last bladder and bowel continence assessment was completed in October 2011. According to the registered staff Resident #725 has varied bladder incontinence. [s. 48. (2) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

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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 did not ensure that resident #675, who was exhibiting skin breakdown and pressure ulcers, was assessed by the registered dietitian who was a member of the staff of the home. The resident was noted to have new open areas however, no referral to the Registered Dietitian was completed and the Registered Dietitian had not assessed the resident in relation to skin integrity. Staff confirmed that a referral to the Dietitian had not been completed. The Food Service Manager confirmed that she was not aware of a referral to the Dietitian related to wounds. [s. 50. (2) (b) (iii)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

- The home's policy related to Skin and Wound (LTCE-CNS-1-1). indicates that weekly assessments of stage 2 wounds or greater are required to be completed by the home's skin care co-ordinator.
- It was first noted that resident # 675 had a wound.
- A review of the wound assessments completed in the month of February 2013 indicated that assessments were completed only three times in the progress notes. An Ontario Wound Assessment was completed in February 2013, but there had been no further completed assessments completed since then. [s. 50. (2) (b) (iv)]

3. The licensee did not ensure that resident # 734 received a reassessment of their wound at least weekly by a member of the registered nursing staff.

- The progress notes for resident # 734 in December 2011 indicated that the resident had developed a stage 2 pressure ulcer.
- The home's policy related to skin and wound (LTCE-CNS-1-1) directs staff to complete weekly wound assessments of resident's with stage 2 wounds or greater.
- A review of the health file for resident # 734 revealed that assessments of the resident's wound were completed several times between December 2011 to April 2012.
- The Treatment Administration Records (TARS) for the resident indicated that the resident frequently refused to have the assessment done. The documentation on the resident's health file did not indicate that the resident refused the assessment and there was no documented assessments completed for these dates.
- It was also noted in the resident's progress notes that their wound was still present by the end of April 2012 and that the wound had not changed much. There was no

further documentation on the resident's health file until July 2012 to indicate that further assessments were completed or when the resident's wound had actually healed.
- A review of the Minimum Data Set assessment completed in July 2012 indicated that the resident's wound was healed.
- During an interview with a registered staff member it was confirmed that the assessments should have been completed weekly for the resident and that these assessments should be documented on the resident's health file. (167)
. [s. 50. (2) (b) (iv)]

WN #14: 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 nutrition and hydration program did not have a system to effectively monitor and evaluate the food and fluid intake of resident #680, who was at high nutritional risk and at risk for dehydration. Resident #680 had a plan of care that directed staff to provide pudding at both meals and snacks. Staff interview confirmed that staff were recording the resident's intake of the pudding in various different spots on the food and fluid intake tracking form and also confirmed that the intervention would not be recorded when provided with meals. An evaluation of the effectiveness of the intervention could not be completed as it was unclear from the documentation if the resident was consuming the nutritional intervention as prescribed by the Registered Dietitian. [s. 68. (2) (d)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that action was taken for resident #679, after a significant weight loss for over a month. The Registered Dietitian noted the weight change, however, queried an error and to wait until the next month for follow up on the October weight. Action was not taken at that time to address the significant weight loss. A re-weigh, to confirm the accuracy of the weight change, had been completed by nursing for the September weight (as noted on the weight tracking record), however, the weight was considered an error by the Dietitian. The Dietitian did not follow up on the October weight as indicated in the September assessment notes. [s. 69.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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. Not all residents were offered the planned menu items at each meal.
a) Residents receiving a pureed menu were not offered pureed bread (as per the planned menu) at the lunch meal. Staff confirmed that three residents were not offered pureed bread with the meal.
b) The planned portion size of menu items was not offered to residents at the observed lunch meal. The planned menu required a #12 scoop of pureed beef, however, a #8 scoop was used; the menu required a #8 scoop of pureed potato salad, however, a #10 scoop was used; the menu required a #8 scoop of pureed sweet potato, however, a #10 scoop was used; the menu required a #8 scoop of broccoli, however, a #10 scoop was used.
Variation in the scoop size would alter the nutritional value of the meal.
c) The planned portion size of menu items was not offered to residents at the observed lunch meal. The planned menu required a #16 scoop minced peaches, however, a #10 scoop was used; #16 scoop of pureed muffin was required, however, a #30 scoop was used, a #16 scoop of minced pears was required, however, a #8 scoop was used. [s. 71. (4)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The home failed to ensure the admission package of information, at a minimum a disclosure of any non-arm's length relationships that exist between the licensee, under other providers who may offer care, services, programs or goods to residents.
Review of the admission packages provided by the business manager and the three resident admission files reviewed did not demonstrate that the admission package included disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents. [s. 78. (2) (n)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulation.

a. The home did not have policy to promote zero tolerance of abuse and neglect of residents posted. [s. 79(3)(c)]
b. The home did not have the policy to minimize the restraining of residents posted, as well as information about how a copy of the policy can be obtained. [s.79(3)(g)]
c. The home did not have the name and telephone number of the licensee posted. [s.79.(3)(h)]
d. The home did not have an explanation of evacuation procedure posted. [s.79.(3)(j)]
e. The home does not have an explanation of whistle-blowing protections related to retaliation posted. [s.79.(3)(p)] [s. 79. (3) (c)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The home failed to seek the advise of Residents' Council and Family Council, if any, in developing and carrying out the survey, and in acting on its results.

According to the President Family Council the results of the survey were shared, however the home did not address how the home will be acting on the negative issues and the home did not seek the advise of the council when developing the survey. Interview with the President of the Residents' Council indicated the home did not seek the council's input in developing the satisfaction survey. [s. 85. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The home failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as following: The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
A verbal complaint from a family member was made to PSWs regarding damage to resident #654's furniture related to the use of a ceiling lift and positioning of the resident's wheelchair. A record of the investigation, and response to the family member was not recorded and the Administrator, Director of Care, Registered Nurse and Registered Practical Nurse for the unit were not aware of the concern voiced by the family member. [s. 101. (1) 1.]

WN #21: 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 home failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instruction for the storage of the drugs.
The emergency drug box which is located on the 2nd floor was observed with the DOC to have one refrigerated medication expired. The DOC stated the medication had just recently been audited by the pharmacist.
The government supply was also observed with the DOC to have five (5) bottles of Novasen to be expired as of January 2013. [s. 129. (1) (a)]

2. The home failed to ensure that drugs are stored in an area on a medication cart that is secure and locked.
Door to the first floor nursing station was propped open, medication room door propped open and unobstructed with access to unlocked medication cart. Inspector was able to go in, open several drawers multiple times without anyone coming around and noticing. Inspector spoke with registered staff after several minutes and she was surprised that it was left open. Cart was locked and inspector left. [s. 129. (1) (a) (ii)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The home failed to ensure that for the purpose of clause 78(2)(r) of the Act, every licensee of a long term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following: The resident's ability under subsection 82(2)of this Regulation to retain a physician or registered nurse of the extended class to perform the services required under subsection 82(1).
Review of the admission package indicated that it did not include information on the ability to retain a physician or RN (EC) to perform the required services to the residents. [s. 224. (1) 1.]

Issued on this 30th day of May, 2013

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