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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2015	2015_330573_0020	O-002288-15	Resident Quality Inspection

Licensee/Titulaire de permis

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St CORNWALL ON K6J 5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET CORNWALL ON K6J 5T2

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

ANANDRAJ NATARAJAN (573), ANGELE ALBERT-RITCHIE (545), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592)

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): July 20, 21, 22, 23, 24, 27, 28, 29, 30 and 31, 2015

The following logs were inspected during this inspection
O-001179-14
O-001229-14
O-001624-15

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Nursing/Acting Director of Care, Director of Support Services/Acting Executive Director, Manager Information System (IS) and Decision Support, Resident Care Assistants Supervisor, Patient/Resident Relations Advisor, Program Support Coordinator, Pharmacy Consultant, Nurse practitioner (NP), In charge Nurse ,Registered Nurses (RN), several Registered Practical Nurses (RPN), several Resident Care Assistants (RCA), Dietary Aide, Housekeeping staff, Maintenance staff, OT/PT Assistant, President of the Residents' Council, several family members and several Residents.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, observed resident care, observed meal services, observed medication administration, reviewed resident health records, reviewed relevant home policies, protocol and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
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
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

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 be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

During an observation of a Medication Pass, Inspector #545 observed RPN S#126 administering insulin and eye drops for Resident #49 while she/he was sitting at the dining room table with other Residents.

During an interview Resident #49 indicated that she/he would prefer if the insulin and eye drops were given in her/his private room, away from other Residents.

On July 28, 2015 during an interview with RPN S#126, she indicated that she usually administered most of the morning medications, including insulin and eye drops to Residents in the dining room. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident's 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 was fully respected and promoted.

During an observation of a Medication Pass for Residents #44, #53 and #54 Inspector #545 observed RPN S#126 discarding the clear plastic medication packages containing Residents' personal health information in the green garbage bag attached to the Med Cart. The Resident's first name and room number, including date, time and detail of each medication was displayed on the medication packages.

During an interview with RPN S#126 following the Med Pass, she indicated that she disposed the Residents' medication packages in the green garbage bag attached to her Med Cart. She further indicated that the green garbage bags were then disposed with other garbage.

On July 27, 2015, during an interview with RPN S#134, she indicated that she placed the empty packages in a glass of water and rubbed off the personal health information of the Residents, RPN S#152 on the second floor indicated to the Inspector that her practice was to rip off the original package to separate name of Resident from the detailed medication information, then throw the packages in the large green garbage bag attached to her Med Cart, added that at the end of the Med Pass she added a little bit of water in the bag containing original medication packages, as well as other garbage, in the hope of erasing personal health information. RPN S#152 indicated that the home had not provided her with a specific process to protect Residents' personal health information.

During an interview with the Acting DOC, she indicated that Registered staff were expected to dispose off the original packages in a way to protect Residents' personal health information. She further indicated that she was aware that some staff discarded the packages directly in the green garbage bags attached to the Med Carts, and that different practices were used in the home, such as adding water to the packages to remove the writing or disposing of them in Sharps Containers. After looking at the original packages for 3 different Residents, the Acting DOC confirmed that the personal health

information for Resident #44, Resident #53, and Resident #54 were not respected. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance (1) to ensure that Resident #49's is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity during medication administration.
(2) to ensure that all Registered Staff protect all Resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 when discarding individual Residents' medication packages during medication pass, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 licensee has failed to ensure that all residents identified with contact precautions have a written plan of care with planned care needs related to infections and provide clear directions to staff and others who provide direct care to the resident.

It was noted by the Inspector #592 that infection control carts containing personal protective equipment (PPE) were located outside the Resident #21 and #45 rooms. Signage indicating contact precautions were posted on each resident's door.

In an interview on July 27, 2015, with RCA S#133, she indicated to Inspector #592 that for Resident #21 Antibiotic-Resistant Organisms (ARO) was present in feces and staff were to wear gloves and gowns whenever they were providing personal care to resident.

Upon a review of recent lab report for Resident #21, which identifies the presence of ARO in the Resident lower back area.

In an interview on July 27, 2015 with RPN S#134, she indicated to Inspector #592 that Resident #21 was diagnosed with an ARO but unsure which area was affected. Upon reviewing the current written plan of care, with RPN S#134 the planned care or directions to staff related to the ARO for the Resident #21 was not identified.

In an interview on July 27, 2015, with RPN S#135 and RCA #S114, both indicated to Inspector #592 that Resident #45 was diagnosed with a specific type of ARO and therefore contact precautions were required.

Upon a review of the current written plan of care with RPN #S135, for Resident #45, planned care or directions to staff related to the presence of ARO or the purpose of the contact precautions was not identified.

Upon a review of the Resident #45's lab report which identifies the presence of a different type of ARO other than RPN S#135 and RCA #S114 stated on July 27, 2015. RPN S#135 indicated that it was possibly an error and confirmed later on that day that Resident #45 was on precautions for ARO that was identified in the Resident lab report.

In an interview on July 27, 2015 with the Acting DOC, she told Inspector #592 that residents who are identified with Contact precautions should have a planned care in the written plan of care providing clear direction to staff regarding precautions required when providing care to the residents. She further added that the plan of care should have been updated by the Registered Staff on the floor. [s. 6. (1)]

2. The licensee has failed to ensure that Residents #12, #18 and #06's written plan of care did not set out planned care for Residents Oral/Dental care.

On July 21, 2015 the Inspector #545 observed a missing upper front tooth while interviewing Resident #12. The Resident indicated she/he lost a tooth during meal time. The Resident indicated that she/he would not be able to see the dentist until a specific month in 2015, and was concerned with the missing tooth as well as another tooth that will require a filling.

A Progress Note on a specific day in May 2015 indicated that the Resident had “broken a tooth in half while eating, that the Resident would be contacting a family member to book a dentist appointment, and that it was the Resident’s own teeth”

When assessed on specific day in June, 2015, no oral problems were identified. It was

also noted that the Resident required limited assistance with personal hygiene, which includes brushing of teeth. It was documented that the resident had loose or carious teeth.

During an interview with RCA S#120 on June 23, 2015, she indicated that she had provided a bath for the Resident earlier in the day, but had not provided any assistance with brushing her/his teeth, and that she was not aware of the Resident having any problems with her/his teeth.

During an interview with RN S#106 on July 24, 2015, she indicated that dental care should be included in the Resident's written plan of care under Activity of Daily Living. After checking the Resident's chart, she indicated that the planned care for dental care was missing. [s. 6. (1) (a)]

3.During an interview with Resident #18, she/he indicated that both her/his upper and lower dentures are old, and that her/his gums were worn out. Later the Resident indicated to the Inspector that she/he selected softer foods at mealtime as she/he was finding it difficult to chew food, especially meats and vegetables.

When assessed on a specific day in July 2015, no oral problems were identified. It was also noted that the Resident required extensive assistance with personal hygiene, which includes brushing of teeth.

Upon review of the Resident's health record, it was documented that Resident #18's was prescribed a regular diet; regular texture and may request minced meat.

During an interview with RCA S#111 and S#112 on June 23, 2015, they indicated that they brushed the Resident's dentures at night, added a cleaning tablet in water and that in the morning the Resident rinsed dentures by her/him self. Both RCAs indicated they believed that Resident #18 had no problems with her/his dentures.

During an interview with RN S#106 on July 24, 2015, she indicated that dental care should be included in the Resident's written plan of care under Activity of Daily Living. After checking the Resident's chart, she indicated that the planned care for dental care was missing. [s. 6. (1) (a)]

4. On July 22, 2015 during Resident observation, Inspector #573 noticed Resident #06 with few missing and unclean teeth in the lower jaw and also no upper teeth or dentures

in place in the upper jaw.

On a specific day in July 2015, the Inspector observed Resident #06 having lunch in the dining room with upper dentures in place. Inspector spoke with RCA S#146 who indicated that Resident #06 does not have any dentures in place and resident oral care is provided with swab stick. The RCA S#146 also indicated that resident needs lot of queuing and encouragement for oral care.

During an interview with another RCA S#121 she indicated to the inspector that Resident #06 has upper dentures and requires total assistance from staff for the oral care and is provided with swab sticks.

Inspector reviewed Resident #06's written plan of care in place which did not identify any information regarding Resident #06 Oral/ Dental Care.

On July 24, 2015 during an interview RPN S#135 after discussion with a RCA S#148 who initially indicated that Resident #06 does not have dentures and later confirmed with the inspector that resident has an upper denture. Further the RPN S#135 mentioned that resident has behaviours where she/he often removes and throws her/his upper dentures on the floor. Inspector reviewed Resident #06's written plan of care with RPN S#135 who confirmed with the Inspector #573 that Resident #06's written plan of care do not indicate regarding the use of dentures and Resident behaviours related to the dentures.

On July 24, 2015 Inspector reviewed Resident #06's written plan of care with Acting DOC who confirmed that Resident #06's written plan of care do not have any information regarding the use of Dentures and further concurred with the Inspector #573 that the written plan of care did not set out any planned care for Resident #06 Oral/ Dental Care. [s. 6. (1) (a)]

5. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and other who provide care with regards to Resident #21's catheter drainage bag care.

Resident #21's health care record was reviewed. Resident #21 had a specific type of catheter since the time of admission.

RCAs S#123, S#136, S#139 and S#138 were interviewed and stated that Resident #21

uses a catheter drainage bag on all shifts.

S#123's process is to empty the catheter drainage bag and record the output. S#123 does not rinse the bag and was not sure how often the bag is changed.

S#136's process is to empty the catheter drainage bag and record the output. S#136 was unsure when the bag was to be rinsed and stated that it was changed weekly on Resident #21's bath day.

S#139's stated that on every shift the catheter drainage bag is to be emptied, the output recorded and the drainage bag rinsed with water and vinegar.

On July 24, 2014, RCA S#125 was interviewed and stated that she was working her first shift on the unit in several years. S#125 stated that on the other unit, she was instructed to change the catheter drainage bag in the morning, rinse it with vinegar and hang it to dry for the next use. S#125 stated that she had provided morning care to Resident #21 which included emptying the catheter drainage bag. She stated that she emptied the drainage bag but did not rinse it.

On July 28, 2015, S#138 was interviewed and stated that she had provided morning care to Resident #21 which included catheter care and bathing the resident. S#138 stated that she had emptied the catheter bag, wiped it down and cleaned the tip. She stated that she did not rinse the bag and that the resident's catheter bag was not changed with this bath but would be at the next bath. Resident #21's next bath was scheduled for a specific day and there was no instruction to change the resident's catheter bag with the bath.

On July 31, 2015, in an interview with the RCA Supervisor, she indicated that she would expect the RCA staff to ask the nurse for guidance regarding catheter drainage bag care. She stated that the written plan of care should provide direction to the staff completing the resident's care.

On July 31, 2015, RPN S#163 who was providing care to Resident #21 on the day shift was not able to advise what direction she would advise the RCAs to follow with regards to Resident #21's catheter drainage bag care.

Resident #21's plan of care was reviewed. Under the focus of Continence Status, clear directions are not set out for the staff in regards to resident catheter drainage bag care. [s. 6. (1) (c)]

6. The licensee has failed to ensure that the resident, the resident's substitute decision maker, if any, and any other persons designated by the resident or substitute decision-maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care.

On a specific day and time Resident #40 was complaining of nasal congestion and shortness of breath. During that period, the home was confirmed with the Respiratory outbreak by the Public Health. Resident #40 was prescribed with new medications and puffers. Resident #40 was put in isolation and Personal Protective Precautions were put in place.

Resident #40 health records indicates that Resident #40 has impairments in decision making and that Resident family member is the substitute decision maker (SDM) for the care. Progress notes were reviewed and no documentation was found about the SDM being made aware of the new changes in treatment for Resident #40 and the sudden change of condition.

On July 29, 2015, in an interview with RPN S#110, she told inspector #592 that Registered staff do not have to call for any changes in the treatments or resident's condition. She further added that there is no policy or expectations directing staff when to contact the SDM.

On July 29, 2015, in an interview with RPN S#151, he indicated that SDMs are to be aware of any changes in condition, treatment or medications. He further indicated that Resident #40 was not able to make her/his own decision due to advance dementia, therefore the Registered staff will contact Resident #40's SDM to report any concerns. RPN told inspector #592 that he was unable to find any documentation that Resident's SDM was notified of the change in treatment and condition for that period of time.

On July 29, 2015, in an interview with the Acting DOC, she told inspector #592 that any significant changes in resident status, such as treatments, condition and medications, that the SDM should be contacted and informed in order for them to participate fully in the development and implementation of the plan of care for residents. [s. 6. (5)]

7. The licensee has failed to ensure that Resident #18 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

Resident #18 was admitted to the home on a specified date with multiple diagnoses and the Resident's cognitive status was borderline intact.

According to the most recent assessment conducted in April 2015, Resident #18 was frequently incontinent of bladder, and it was indicated that the Resident wore pads or briefs. It was also documented that the Resident required extensive assistance of one person with toileting and personal hygiene and that the Resident ambulated with a walker.

Upon review of the most recent Plan of Care, it was indicated that Resident #18 was administered diuretics daily and was encouraged to drink plenty of fluids throughout the day. Under the section Bladder Incontinence, it was documented that the "Resident will have less episodes of stress incontinence, that she/he wore pull-ups supplied by the home and to encourage the Resident to toilet her/himself more often before the urgency hits".

During an interview with Resident #18 she/he indicated to the Inspector that she/he wore pull-ups during the day as she/he had occasional accidents and that she/he was able to walk to the bathroom using her/his walker. The Resident further indicated that she/he required assistance of staff to change the pull-up. The Resident indicated that around a specific time in the night staff put a "diaper" on and that she/he did not get up to go to the bathroom as feared falling, but was often aware when she/he was incontinent. Resident #18 indicated that staff told her/him that it was OK to urinate in the "diaper" as they would come around to change it three times per night, however lately they have been changing the brief once per night.

On July 24, 2015 during an interview with RCA S#122, she indicated that Resident #18 used to get up at night but stopped about 2 years ago, probably because she/he was afraid of falls. The RCA indicated that the Resident wore pull-ups during the day and a brief at night. The RCA S#122 further indicated that at night the brief is changed twice and that it is always wet, added that the Resident sometimes rang the bell as had some bladder control and was aware when she/he was wet.

RPN S#156 and S#110 indicated to the Inspector on July 24, 2015 that the Resident used pull-ups on days and a brief at night. They indicated that the Resident was independent with toileting on days and evenings but was incontinent at night. RPN S#110 indicated that the Resident received assistance from staff at night to change

her/his brief. They indicated that they were not aware of any incontinence assessment conducted for Resident #18.

During an interview with RN S#106 on July 24, 2015, she indicated that Resident #18 should be reassessed for bladder continence and possibly toileted on night shift as she/he is known to having some bladder control.

Resident #18's continence program was not reassessed and the plan of care not revised in relation to Resident night time bladder continence issues. [s. 6. (10) (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 (1) to ensure that all residents identified with contact precautions have a written plan of care with planned care needs related to infections and provide clear directions to staff and others who provide direct care to the resident.
(2) to ensure that there is a written plan of care that sets out the planned care for the Resident #12, #18 and #06 related to Oral/Dental care.
(3) to ensure that Resident #21 written plan of care provide clear direction to staff with regards catheter drainage bag care.
(4) to ensure that the Resident#40's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.
(5) to ensure that Resident #18's continence program were reassessed and the plan of care revised in relation to Resident bladder continence issues, to be implemented voluntarily.

WN #3: 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. The licensee has 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; and cleaned as required.

On July 20, 2015, Inspector #592 observed the following unlabelled personal care items: On McNeil House spa room there was 1 comb and 2 hairbrushes with hair on their bristles and 3 Deodorant roll-on sticks. On Kane House spa room there was 2 combs and 2 hair brushes with hair on their bristles.

On July 20, 2015, Inspector #573 observed the following unlabelled personal care items: On Quinn House in a shared resident bathroom,1 pink used razor and 1 black comb.

On July 21, 2015, Inspector #545 observed the following unlabelled personal care items: On Mantle House in a shared resident bathroom, 2 toothbrushes in a ceramic glass and 2 blue denture cups. Several days after inspector #545 also observed some dusting Powder (1 green container, 1 pink container) with puffs not labelled.

On July 22, 2015, Inspector #551 observed the following unlabelled personal care items: On Albert House in a shared resident bathroom, 1 electric razor and 2 Deodorants sticks.

On July 23, 2015, Inspector #592 observed the following unlabelled personal care items: On Albert House spa room there was 1 black comb.
On Kane House spa room, 3 black combs and 2 hair brushes with hair on their bristles.

On July 23, 2015, in an interview with RCA S#113 and S#114 on the Kane and Albert House spa, they both confirmed that they were not able to identify to whom the

unlabelled personal items belonged to.

On July 23, 2015, in an interview with RPN S#101, she told inspector #592 that she was not able to identify to whom the unlabelled personal items found in the Kane House spa belonged to. She further added that personal items are expected to be labelled for each resident upon admission and upon acquiring new belongings.

On July 23, 2015, in an interview with the Resident Care Aide Supervisor, she told inspector #592 that each resident was assigned at admission a drawer and a cupboard in a shared bathroom respectfully, resident located on the right side of the room will use the right cupboard and drawer and resident located on the left side of the room will be assigned on the left cupboard and left drawer. She further indicated that the home is not labelling any personal items but the expectations is to have the items kept in place in the appropriate area and if personal items are brought out of the room, personal items must be brought back to the room or labelled.

On July 24, 2015, the Resident Care Aid Supervisor provided to Inspector #592 a clarification note for the expectation/practice in the nursing department for the labelling of personal items. The note is indicating that all personal items such as toothbrush, comb/brush, creams, toothpaste, razors, should be labelled with permanent marker and to ensure that replacements are subsequently labelled for all residents. [s. 37. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his or her personal items labelled, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On July 21, 2015 at 08:50, on Kane House, Inspector #592 observed a Medication Cart at the entrance of the Dining Room, unlocked and unattended. On top of the cart, a bottle of lactulose was observed. A RCA Staff was talking with a Resident and indicated to the Inspector that she didn't know where the nurse had gone. The RPN returned to the Med Cart shortly after.

On July 27, 2015 during an observation of a Medication Pass on the Mantle House, Inspector #545 observed the Med Cart unlocked and unattended at the following times:
-at 07:36, observed the Med Cart outside a Resident room; RPN S#126 was heard talking with a Resident inside the Resident room
-at 07:45, RPN S#126 placed the Med Cart at the entrance of the Dining Room, behind a half wall - she left the cart unlocked each time she left to administer medication, eye drops, nostril spray and insulin to the following Residents sitting at different tables in the Dining Room:
-at 07:49, med cart left unlocked/unattended, while RPN administered medications and insulin to Resident #44
-at 07:51, med cart left unlocked/unattended while RPN administered medications and eye drops to Resident #12
-at 08:00, med cart left unlocked/unattended while RPN administered eye drops and

medications to Resident #48
-at 08:03, med cart left unlocked/unattended while RPN administered eye drops, nostril spray and medications to Resident #49
-at 08:12, med cart left unlocked/unattended while RPN administered medications to Resident #50

On July 29, 2015 at 15:15, the Med Cart on Albert House was found by Inspectors #551 and #545 unlocked and unattended, there was no registered staff in the vicinity. At 15:20, Inspector #545 asked a RCA which nurse was working this evening, and he indicated he didn't know.

During an interview with the Acting DOC on July 29, 2015, she indicated that the home's policy clearly stated that the medication cart must be locked at all times when not in use and when out of view of the nurse, added that the risk increased especially on those units where Residents were known to wander. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs are stored in an area that is secure and exclusively for drugs and drug related supplies.

On July 21, 2015, Inspector #592 observed prescribed creams stored in blue baskets in both the Personal Care Centre's on the 3rd floor.

On July 27, 2015, Inspector #545 observed prescribed creams stored in a green plastic container located in the Clean Utility Room (#3242) on the third floor, such as

-Desonide Cr 0l.5% 180gr, 4 jars
-Metrocream 0.75% 60gr 1 jar
-Sandox Anuzinc 30gr, 1 jar
-Behamethasone Vlaerate 0.05% 50gr, 1 jar
-Terbinafine HCl 1% 30gr, 1 jar
-Clothrimazole Cr 1% 100gr, 2 jars
-Nystatin 100,000u/g 100gr, 1 jar

During an interview with RCA S#129 on July 27, 2015 she indicated that some prescribed creams were kept in the Clean Utility Room and others were kept in the Residents' rooms, locked in the top drawer of their night table.

On July 27, 2015 during an interview with the Acting DOC, she indicated that she

believed that all prescribed creams were kept locked and secure.

As such prescribed creams are not stored in an area that is secure and used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

3. The licensee has 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.

On July 27, 2015 during an observation of a Medication Pass, Inspector #545 observed Resident #44's morning dose of narcotics stored in a clear plastic package with other medications. The clear plastic package was stored in the Resident's medication bin in the Med Cart which was observed unlocked and unattended over the course of the Medication Pass.

During an interview with RPN S#126 she indicated that all regular doses of narcotics and controlled substance were prepared and delivered by the home's pharmacy (Medical Arts Pharmacy) with other medications, added that only the PRN narcotics and controlled substances were double-locked in the narcotic box located in the bottom drawer of the Med Cart.

On July 31, 2015 the Pharmacy Consultant S#165 indicated to the Inspector that the regular doses of narcotics have been dispensed with non-narcotic medications since 2010, when the Catalyst Medication Administration Record System was implemented.

During an interview on July 27, 2015 with the Acting DOC, she indicated that regular doses of narcotics and controlled substances were not kept in a double-locked area, added that in discussion with the home's Pharmacist Consultant, it was decided that this practice would be acceptable. The Acting DOC further indicated that she was aware that narcotics and controlled substances needed to be 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 (1) to ensure that drugs are stored in an area or a medication cart, that is secure and locked.
(2) to ensure that drugs are stored in an area that is secure and exclusively for drugs and drug related supplies.
(3) to ensue 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, 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if the staff member has been trained by a member of the

registered nursing staff in the administration of topicals.

The Inspector reviewed the Home's policy titled: Application of Medicated Creams, Ointments and Lotions, policy number 14-a-37 (revised: 02 May 2012). Under the section Procedure, it is indicated that "When transcribing the order the Registered Nurse/Registered Practical Nurse may delegate the act to the Resident Care Aides providing the following criteria are met. The Registered Nurse/Registered Practical Nurse will:
1.1 sign for the prescription on the electronic Medication Administration Record (eMAR). He/she is further responsible to ensure the prescription has been applied appropriately;
1.2 physically examine the affected area(s) and document the findings in the electronic Progress Notes at least weekly;
1.3 review with the physician the resident’s ongoing need for the prescription at least quarterly

On July 21, 2015, Inspector #592 observed Residents' prescribed creams in blue baskets in both Personal Care Centres.

On July 27, 2015, Inspector #545 observed Residents' prescribed creams in a light green plastic container with a cover in the Clean Utility Room #3242 and Resident #44's prescribed topical creams in the top drawer of her/his night table, a key was left in the key hole and the drawer was opened.

On July 27, 2015, RCA S#131 and S#129 indicated that they applied prescribed creams to Residents. RCA S#131 indicated that when a Resident was prescribed a new cream, the nurse gave the RCA the jar and she followed the instructions as per the label on the jar. RCA S#129 indicated that she had started working in the home one month ago and RCA S#131 indicated that she had been working in the home for 3.5 years, both RCAs indicated that they had not received training in the application of prescribed topical creams.

During interviews with RCAs S#142, S#120, S#154 on July 29, 2015 they indicated that they applied prescribed creams to Residents as per the label on the containers of the prescribed creams. They indicated that no registered staff had provided them with training in the application of topical prescribed creams. RCA S#128 indicated she was a nursing student working in a role of RCA for the summer, that she applied prescribed creams and that she had not received any training on the application of topical prescribed creams.

On July 27, 2015 RPN S#126 indicated that RCAs were responsible to applying prescribed topical creams and that she signed the Medication Administration Record when the RCA informed her that the application was done. The RPN indicated that she had never provided training to any RCA on the application of prescribed topical creams. The RPN indicated that she believed that application of topical creams was provided as part of the RCA course.

During an interview with the Acting DOC on July 29, 2015 she indicated that RCAs in this home were not provided training by registered staff in the application of prescribed topical creams. [s. 131. (4)]

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

The Inspector reviewed the home's policy: Administration of Non-Narcotics, policy number 14-a-24. Item 1.6 indicates that "the RN/RPN will not allow residents/patients to self-administer any medication unless specifically ordered to do so".

On July 22, 2015 Inspector #545 observed two jars of prescribed topical creams on the counter in Resident #15's bathroom. The Resident indicated that she/he applied the cream her/himself. The Resident added that she/he had a locked drawer in her/his night table with a key but preferred to keep the cream in the bathroom as it is more convenient.

Upon review of the Resident's most recent plan of care, it was indicated that Resident #15 was prescribed topical creams and to apply to a specific area until clear. The first fill of this prescription was dated on a specific day in November, 2014.

In discussion with RCA S#142, S#154 and S#128 they indicated that the Resident was known to apply the prescribed cream to a different area several times per day. They indicated that the cream was prescribed for a rash to a specific area but that the Resident insisted on using it on a different area. The RCAs indicated that the registered staff were aware that the Resident kept the prescribed cream unlocked in her/his bathroom but let the Resident do what she/he wanted.

On July 29, 2015 during an interview with RPN S#110, she indicated that the RCA

supervisor had left a jar of prescribed topical creams on the counter in the Nursing Station earlier today, indicating that it was found in the Resident's bathroom. The RPN indicated that the cream was prescribed for a rash in a specific area but the Resident was using it on a different area. The RPN indicated that there was no physician order for self-administration.

On July 29, 2015 the Acting DOC indicated that only Residents with a physician order for self-administration of a prescribed topical cream would be allowed to self-administer and keep it in their room, under locked key. [s. 131. (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 ensue that Resident #015 does not administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, 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).

Findings/Faits saillants :

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

On July 27, 2015 between 07:35 and 08:15, Inspector #545 observed RPN S#126 conduct a Medication Pass in Mantle House for several Residents without washing her hands.

At 07:35, the Inspector observed RPN S#126 in Room #3132 completing administration of medication with a Resident. Upon returning to the Med Cart outside the room, the RPN

signed off administration of medications and accompanied of the Inspector walked to the Dining Room and placed the Med Cart at the entrance. A hand sanitizer dispenser was observed on the wall at the entrance of the Dining Room.
- at 07:41, RPN S#126 prepared medications, including insulin for Resident #44 and administered these medications to the Resident at a dining room table
-at 07:51, RPN S#126 prepared medications, including eye drops for Resident #12 and administered these medications to the Resident at a dining room table, then returned to the Med Cart
-at 07:59, RPN S#126 prepared medications for Resident #17 and administered these medications to the Resident at a dining room table
-at 08:00, RPN S#126 prepared insulin, eye drops and other medications for Resident #48 and administered these medications to the Resident at a dining room table
-at 08:03, RPN S#126 prepared insulin and administered it at the entrance of the dining room then she prepared eye drops and several other medications for Resident #49 and administered them to the Resident at a dining room table

During the observation, at no point did RPN S#126 washed her hands as she prepared and administered insulin, eye drops and other medications to five Residents.

During an interview with the Acting DOC on July 27, 2015 she indicated that registered staff were expected to clean their hands between each Resident, added that hand sanitizers were available at the point of care in Residents' rooms and in Residents' common areas. [s. 229. (4)]

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

On July 24, 2015, Resident #21 had an isolation cart and contact precautions posted outside the room. It was confirmed that the contact precautions had been implemented due to the resident testing positive for Antibiotic-Resistant Organisms (ARO).

The contact precautions directed staff to wear a gown and gloves for all activities in the room.

On July 24, 2015, RCA S#125 was observed to empty Resident #21's catheter drainage bag wearing one latex glove on her hand. She was observed to reinsert the tip into the drainage bag using the hand that was not gloved and to manipulate the drainage bag using the hand that was not gloved. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the home's infection prevention and control program, to be implemented voluntarily.

WN #7: 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. The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On July 27, 2015 at 07:35, accompanied by RPN S#126, Inspector #545 observed the door of the Storage Room wide open. On the door of the storage room, a sign indicating "Oxygen, No Smoking, No Open Flames" was observed, Inside the room three Liquid Oxygen tanks were observed as well as electrical panels, and personal care items such as mouth wash and toothpaste. RPN S#126 tried several times to pull the door closed and when was unable to, she went behind the door, removed a belt that was holding the door opened and indicated to the Inspector that the door should always be kept closed as it was a non-residential area. A striped pink/white/green belt with a black plastic buckle attached to a metal pipe behind the door of the Storage Room was observed.

On the same day, accompanied of the Acting DOC and the Acting Executive Director, the pink/white/green belt was observed on a hook by the door in the Storage Room. The Acting Director of Care indicated that all staff had a Master Key to access the Storage Room and that the door should be kept closed at all times. [s. 9. (1) 2.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that equipment is maintained in a good state of repair.

The call system used in the home is an Austco System with Connexall. The call system is programmed using a radio frequency and a pager system, on all of the five units in the

home.

On July 21, 2015 at approximately 11:15, the Inspector pulled the call bell by the Resident's bed side in a specific resident room. A white light lit up outside the room and displayed the specific resident room number on the display hanging from the ceiling in the hallway. There was no audible sound that could be heard. After ten minutes, the Inspector came out of the room and a family member indicated that the call bells frequently did not work on the Kane House and that staff had told her/him to pull the bell in the bathroom if required assistance as the sound from the bathroom bell is loud and the staff will be able to hear it. Shortly after, RCA S#102 arrived, indicating that she had noticed the room number on display, but had not received a pager to alert her that a call bell was activated from the specific resident room. Pager #15 was verified by the inspector and the specific room number was not displayed, and the RCA indicated that the batteries were fully charged and tested the sound and vibration in presence of Inspector. RCA S#157 arrived and indicated that she had pager #13 and that it had not been activated either, she as well tested her pager for functionality and sound/vibration were observed. RPN S#101 who was passing medications nearby, indicated that this was not a new problem, that there were many problems with the pagers. The RCA Supervisor arrived and took both pagers from the RCA and indicated that she would have the IT staff check them, added that she thought the problem might be related to batteries.

On July 23, 2015 at 09:45, Inspector #545 heard a loud bell on Kane House. The display hanging from the ceiling in the hallway was blank, not displaying a room number. At approximately 09:50, RCA S#102 and S#113 walked by the Inspector and indicated that their pagers (#15 and #16) had not been activated and they did not know where the sound came from. At 09:54, RCA S#118 arrived and indicated that her pager (#13) did not activate either. RCA S#102 indicated that this was not a new problem, and that it had occurred in the past. All three RCAs did a room check of the entire unit and informed the Inspector that none of the call bells in the rooms and bathrooms on the unit had been activated. Approximately 10 minutes later the sound stopped; RCA S#102 indicated that she had reset the call bell in the bathroom of specific resident room, that this had happened in the past and by pulling the call bell cord out in the bathroom of that room, it had resolved the issue. The call bell in a resident room was re-activated and RCA S#113 indicated that her pager (#16) had not been activated. RPN S#101 indicated to the Inspector that she remembered that this same issue had occurred approximately four months ago and staff were told to unplug the cable that connected to the Call Bell Console at the Nursing Station and that this would reset the system and resolve the

issue.

During an interview with the RCA Supervisor on July 23, 2015 she indicated that there were usually no problems with the call system, including the pagers but that she had brought new batteries in case the problem was related to faulty batteries. She further indicated that the call system was managed by IT S#158 who was on holidays at this time but that his replacement S#116 would follow-up on the issue. The RCA Supervisor indicated that there had been an easy fix to the problem today, that the call bell in a specific resident room was reset by pulling it out and re-inserting it.

On July 29, 2015 during an interview with the Director of Support Services, he indicated that the call bell cord in the specific resident room was faulty and had been changed and the issue was resolved. He indicated that the home had developed a process whereby all staff could initiate a work order and request maintenance for call bell issues or any other issues from any Unit computers in the home. He indicated that call system issues are looked at immediately when his team were notified of problems. The Director of Support Services indicated that there is no work order placed to alert his team of call system issues that occurred on Kane House on July 21, 2015 and July 23, 2015.

On July 30, 2015 during an interview with IT S#158 he indicated that staffs are expected to test all pagers at the beginning of each shift and to complete a work order immediately to alert Maintenance, if there are issues, so they can be resolved. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On four specified dates in July, 2015, Inspector #573 observed Resident #03, with long facial hair visible on chin and upper lip.

Inspector #573 reviewed Resident #03's current plan of care which indicates that resident requires assistance for bathing and grooming and also identifies that resident exhibits Resistive behaviours for Activities of Daily Living (ADL) Care. The interventions in place in the plan of care indicates that if resident refuses and resistive for care, staff to use with Gentle Persuasive Approach (GPA) technique to encourage resident to participate with care and if resident still resists for care staff to reapproach the resident later.

On July 27, 2015 Inspector #573 spoke with RCA S#144 who indicated that Resident #03 facial hair is removed on bath days. Further the staff indicated that resident received her/his bath and personal hygiene this morning and was resistive for removal of facial hair. The RCA S#144 also indicated that if Resident resists for care she would usually reapproach again but since she was busy with other residents and with documentation she did not reapproach the resident today to provide the care.

Inspector confirmed from the home's bath schedule that Resident #03 was scheduled for two bath/showers each week. Upon reviewing the RCA documentation (Bathing/ Personal Hygiene) it is confirmed that resident received a bath as per the schedule.

On July 27, 2015 RPN S#145 observed Resident #03 in the presence of the inspector and concurred that resident facial hair is to be removed by the RCA staffs and further indicated that Resident #03 is responding to the current interventions in place for Resistive behaviours for ADL Care.

Resident #03 did not receive individualized personal care for removal of facial hair, on a daily basis. [s. 32.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

In a review of Residents' Council meeting minutes, it was documented that residents had brought forward several concerns as part of a round table discussion.

At the October 14, 2014 Residents' Council meeting, several concerns were expressed, including with regards to: sub-optimal room temperatures, recommendation for vending machine for fundraising, staff routines, amount of paper work completed by RCAs and need for more staff supervision. The ED responded on November 6, 2014.

At the November 29, 2014 Residents' Council meeting, several concerns were expressed, including with regards to: bottled water, garbage bins, recycling, cleanliness, bath linens and dietary issues. The ED responded on December 16, 2014.

At the January 13, 2015 Residents' Council meeting, several concerns were expressed, including with regards to: thermostats on Kane House, food temperatures, salt and pepper shakers, hot water, bed sheets and locking of storage rooms. The ED responded on February 4, 2015.

At the March 10, 2015 Residents' Council meeting, several concerns were expressed, including with regards to: dining room tables on Kane House, linen carts, menu items, the volunteer newsletter and staff members attitudes during the provision of care. The ED responded on meeting on April 7, 2015.

On July 31, 2015, the Executive Director (ED) reported to inspector that she reads the minutes of the Residents' Council meetings regularly and further indicated that a written response is not provided within 10 days to the Residents' Council when concerns or recommendations are brought forward. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On July 27, 2015, Inspector #545 observed the door of the Personal Care Centre on Mantle House opened and unlocked. In a cupboard above the sink the following hazardous products were observed:
•Whirlpool disinfectant cleaner (CLASSIC) - HAZARDOUS - Corrosive: 2 bottles (3 litre) indicating that the product can cause irreversible eye damage and skin burns. Harmful if swallowed
•DIVERSEY, Crew Super Blue, mild Acid Cleaner, causes eye and skin irritation, coded as "2" moderate health hazard

RCA S#128 indicated on July 27, 2015 that the door of the Personal Care Centre was usually left open between 0700 and 0900, until staff started to bathe Residents.

The Material Safety Data Sheet (MSDS) for the Classic Whirlpool Disinfectant Cleaner and the Diversey Crew Super Blue Mild Acid Bowl Cleaner were provided and reviewed by the Inspector:
•Classic Whirlpool Disinfectant Cleaner: Hazard Health Rating = 2 (Moderate),requiring personal protective equipment (glasses and gloves)
•Diversey Crew Super Blue Mild Acid Bowl Cleaner: Hazard Health Rating = 2,requiring personal protective equipment (glasses and gloves)

On the same day, accompanied of the Acting Executive Director, he indicated that the doors of the Personal Care Centres on all units were often kept opened to allow heat and humidity to escape. He indicated that both products were hazardous, then indicated that the whirlpool disinfectant should be kept locked in a cupboard but none were available at this time in the Personal Care Centres. The Acting Executive Director removed the Crew Super Blue toilet cleaner from the cupboard and indicated that the Crew Super Blue toilet cleaner should be kept on the Housekeeping Carts and that housekeeping services was available 7 days per week.

On July 28, 2015, the Acting Executive Director indicated to the Inspector that locks were installed on the cupboards of all Personal Care Centres in the home, and the hazardous products were no longer accessible to Residents. [s. 91.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that home's written Least Restraint policy under section 29 of the Act deals with O.Reg 79/10, s.109 (c) and (e).

In accordance with the LTCHA 2007, s.29 and O.Reg 79/10, s.109 every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with
(c) Restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.

On July 29, 2015 Inspector reviewed the home's Policy for Least Restraint – Long Term Care and Complex Continuing Care Policy Number 11-a-178 which was last updated in June 19, 2014. The home's Policy Number 11-a-178 does not deal with the required information in accordance with O.Reg 79/10, s.109 (c) Restraining under the common law duty pursuant to subsection 36 (1) and (e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented.

On July 29, 2015 Inspector reviewed the home's Policy for Least Restraint – Long Term Care and Complex Continuing Care Policy Number 11-a-178 in the presence of The Director of Nursing and the Program Support Coordinator and both confirmed with the Inspector #573 that Policy Number 11-a-178 does not contain the required information in accordance with O.Reg 79/10, s.109 (c) and (e). The following required information was identified by the Director of Nursing as not being included in the home's Policy for Least Restraint – Long Term Care and Complex Continuing Care Policy Number 11-a-178

Further the Director of Nursing and the Program Support Coordinator both indicated to inspector that they will update the home's Least Restraint policy with accordance to the legislation requirement. [s. 109.]

Issued on this 15th day of September, 2015

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

Original report signed by the inspector.