Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2014	2014_301561_0018	H-001077-14	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

DARIA TRZOS (561), DIANNE BARSEVICH (581), LALEH NEWELL (147), VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 12, 13, 14, 15, 19, 21, 22, 25, 26, 2014

The following log numbers were completed during this inspection: H-000407-14, H-001031-14 and H-000636-13.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Resident Assessment Instrument/Quality Improvement (RAI/QI) RAI Lead, Resident Assessment Instrument/Quality Improvement (RAI/QI) Infection Control Nurse, Resident Assessment Instrument/Quality Improvement (RAI/QI) & Wound Care Nurse, members of the Registered Nursing staff including Registered Nurses(RN) and Registered Practical Nurses(RPN), the Director of Environmental Services, the Personal Support Workers(PSW), Food Service staff, residents and family members of residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, relevant policies, procedures and practices and interviewed staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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 did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A) Resident #032 was observed sitting in a tilt wheelchair with two rolled towels in the palm of their hands. The written plan of care indicated the resident had bilateral hand contractures. They had a palm protector applied on the left hand and a folded towel on the right hand daily. This was removed at bedtime. The personal support worker (PSW) stated that the resident did not have a palm protector splint and that rolled towels were placed in both palms to help prevent further contractures at all times. The Registered staff and the PSW confirmed that the Personal Care Observation and Monitoring Form which was part of the plan of care, did not provide clear directions for the application of the hand towels.(581)

B) Resident #038 was observed with two palmar splints in their hands. The written plan of care indicated that the resident was to have rolled-up towels on bilateral hands daily, to take them off at night and to trial Therapickle splints. The Registered staff and the PSW stated the resident had two hand splints which were put on every morning and removed when they went to bed at night to prevent further contractures. The Registered staff and the PSW both confirmed there were no clear directions for the application and removal of the hand splints as it was not documented in their Personal

Care Observation and Monitoring Form.(581)

C) Resident #002 was observed in an electric wheelchair with their hand placed in a specialized arm rest that acts as a splint to prevent contractures. The PSWs stated they placed the resident's hand in the splint when they are in the electric wheelchair and apply the velcro straps. The Registered staff and the PSWs confirmed there were no clear directions documented in their Personal Care Observation and Monitoring Forms or their Personal Care Profile when to position the resident's hand in the specialized arm rest. [s. 6. (1) (c)]

2. The licensee did not ensure that the resident was 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 changed or care set out in the plan is no longer necessary.

A) Resident #032 was observed with two rolled towels in both hands. The written plan of care indicated the resident had a palm protector on the left hand and folded towel on the right hand and was removed at bedtime. The registered staff and PSW stated the resident did not have a palm protector splint and rolled towels where placed in the palms of both hands during the day and night to help prevent contractures. The Registered staff confirmed that the plan of care for application of the rolled towels was not updated to reflect this change. Resident #032's plan of care was not reviewed and revised when the resident's care needs had changed.(581)

B) Resident #029 was observed sitting in a tilt wheelchair on August 15, 2014. The written plan of care indicated the resident was currently using a manual wheelchair to propel. The Registered Practical Nurse (RPN) stated the resident was using a tilt wheelchair for over a year and the written plan of care was not updated to reflect this change. Resident #029's plan of care was not reviewed or revised when the resident's care needs had changed.(581)

C) Resident #038 was observed sitting in a tilt wheelchair with a hand splint on their left hand and a rolled towel in their right hand. The PSW stated the resident had two hand splints but their right hand had a small open area so a rolled towel was used instead. The written plan of care identified that the resident had bilateral hand contractures and rolled towels on both hands were to be applied daily and taken off at night and to trial therapickle splints with finger separators once delivered. The Registered staff stated the resident does wear the therapickle splints daily and confirmed that the written plan of care was not updated to reflect hand splints were

now being applied daily. The PSW stated that the resident has been wearing the hand splints for over a year. The Resident Assessment Instrument (RAI/QI) Lead confirmed that hand splints were applied daily to help prevent contractures and that the plan of care for application and removal of the hand splints was not updated to reflect this change. Resident #038's plan of care was not reviewed or revised when it was documented in the clinical record that the resident's care needs had changed. (581)

D) The resident #006's Personal Care Profile for June 2014 stated that the resident had full dentures and required "setup" assistance. The resident stated they required assistance with their oral care. PSWs confirmed that the resident required complete assistance with oral care since a change in health condition that occured last year. A progress note dated from August 2014 identified to the Charge Nurse that the resident had complained that they had not had their teeth brushed for the previous four days. The Personal Care Profile and progress notes that provided direction to the personal support workers remained unchanged. A Registered staff confirm that the information should have been updated in the Personal Care Profile to provide accurate information to the personal support workers who provide care. [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 to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and to ensure that the plan of care is reviewed and revised when the resident's needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy called "Administration of Medications" revised May 2014, stated that "multi-dose liquid medications will be dated when opened (i.e., Insulin, TB serum, eye drops, lactulose, cough syrop" and "medications which are not labeled and/or expired are to be discarded)".

Lantus SoloSTAR and Humalog Kwikpen were found in the medication cart on August 19, 2014 unlabeled. Lantus SoloSTAR did not have a date of when it was opened. Registered staff confirmed that the insulin pens should have been labelled and should have had the date of when opened.

2. The home's policy called "Administration of Medications" revised May 2014, stated that "No Team Leader will give a medication prepared by someone else, nor chart a medication as given unless they have personally given the medication. Never leave medication for the Resident to administer to him/herself unless there is a Physician's Order allowing that person to self-medicate."

Resident #200 was observed on August 12, 2014 to have medications in their bathroom and confirmed that they were self-administering them. According to Resident's Medication Administration Record (MAR) these medications were charted as given by registered staff. Registered staff confirmed that resident had medications in their room and was self-administering them. The clinical record and the interview with Registered staff confirmed that there was no order by a physician allowing the resident to self-medicate. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents.

A) Resident #029's bed was observed with two assist rails raised. The PSW stated that the resident had both rails raised when in bed for bed mobility and positioning. The registered staff confirmed that the resident had both bed rails raised when in bed and no bed rail assessment was completed to determine if the bed rails were being used as a Personal Assistance Services Device (PASD). The Director of Nursing confirmed that the bed system for all beds in the home had not been evaluated to minimize the risk to the residents.

B) Resident #038 was observed in bed with two assist rails raised. The PSW stated that the resident had both rails raised when in bed for safety. The RAI/QI Lead stated that their bed rails were changed on May 7, 2014 from two three quarter rails to two assist rails. The RAI/QI Lead stated that a ten day post restraint observation period should have been completed but the home was unable to provide documentation that this was done. The RAI/QI Lead confirmed that the resident had two assist bed rails raised when in bed and no bed rail assessment was completed to determine if the bed rails were being used as a PASD. The DON confirmed that the bed system for all beds in the home had not been evaluated to minimize the risk to the residents. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when the resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #027 experienced an unwitnessed fall in March 2014. The investigation noted the resident was attempting to transfer between the wheelchair and the bed when they slid down on their wheelchair. A visitor who found the resident noted they were "facing the bed, (their) butt was on the foot peddles" with one of their legs stretched out and the other leg to the side like the resident was trying to get up. The resident required three staff to transfer them back to the chair. The resident suffered a fracture of the lower right leg.

The home's Fall Prevention and Management policy, dated January, 2014 described a fall as a "sudden, uncontrolled, unintentional downward displacement of the body to the ground or other object". The Fall Prevention and Management Policy identified that the Fall Incident Report Form was to be used to document the fall. Furthermore, as per the policy, the head injury routine should have been initiated as there was no witnesses to the fall. The DON confirmed the member of the registered staff did not consider the event a fall and did not complete the fall assessment process and did not initiate the head injury routine.

The member of the registered staff completed an incident report regarding the event. According to the Incident Report policy dated January 2013, if there was no apparent injury upon initial assessment, the team leader would follow-up with and document every four hours for twenty-four. The resident was not assessed again until 1900 hours when a PSW identified that the resident had had a large bruise with swelling and fluid discharge on her lower leg.

The home did not ensure a resident was fully assessed and monitored by registered staff after an unwitnessed resident fall. [s. 49. (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 when the resident falls, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, 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. (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 did not ensure that a resident does not administer a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Resident #200 was observed on August 12, 2014 to have medications in an unlocked cabinet in a shared bathroom. The resident who was cognitively intact confirmed they were taking these medications on their own. The Registered staff confirmed that the resident kept medications in their room and was taking them independently. There was no indication in the clinical record or in the physician's orders stating that resident was able to keep medications in their room and to self-administer. Registered staff confirmed that the physician's order was not obtained for this resident to administer medications to herself. [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 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, 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that each resident admitted to the home were screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

Review of the clinical record indicated that resident #101 did not have tuberculosis screening when they were admitted to the home. This was confirmed by the DON and registered staff. [s. 229. (10) 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 admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #7: 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. (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 alternatives to the use of a PASD had 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.

Resident #029 was observed sitting in a tilt wheelchair on August 15, 2014. Review of the clinical record indicated that the resident received a tilt wheelchair over a year ago and there was no assessment completed to determine if the tilt wheelchair was being used as a (PASD) or a restraint.
The RAI/QI Lead confirmed that resident #029 was not assessed to determine if the tilt wheelchair was being used as a PASD or a restraint.

2. The licensee did not ensure that the use of the (PASD) was approved by any person provided for in the regulations.

Review of the clinical records for resident #029 indicated there were no documented approvals for the use of the tilt wheelchair as a PASD. The RAI/QI Lead confirmed that there were no approvals for the use of the PASD.

3. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision maker of the resident with authority to give consent.

A) Review of the clinical record indicated resident #029 or their substitute decision maker (SDM) did not provide consent for the use of their tilt wheelchair as a PASD or restraint. The RAI/Q Lead confirmed there was no consent signed from the resident or their SDM for use of tilt wheelchair as a PASD or restraint.

B) Review of the clinical record indicated resident #038 or their substitute decision maker (SDM) did not provide consent for the use of their tilt wheelchair as a PASD or restraint. The RAI/QI Lead confirmed there was no consent signed from their SDM for the use of tilt wheelchair as a PASD or restraint. [s. 33. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

According to the progress note-wound assessment, resident #041 had pressure ulcers, some more chronic. Progress notes-skin dated July 5, 2014 indicated resident also developed a blister. The review of clinical record indicated that the skin assessment using a clinically appropriate assessment instrument was only done for the more chronic wound. The Wound Care Nurse confirmed that the home used the Wound Assessment Tool (adapted from Bates-Jensen Wound Assessment Tool) to be completed weekly for only stage 2 and higher or for more chronic wounds. All other skin breakdowns were assessed using progress notes. The DON confirmed the same. The home did not ensure that residents exhibiting altered skin integrity received a skin assessment using a clinically appropriate assessment instrument for skin and wound assessment. [s. 50. (2) (b) (i)]

WN #9: 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 did not ensure the resident admission package of information included: (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, (n) 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:

The General Manager checked "No" to the following items on the LTCH Licensee Confirmation Checklist: Admission Process. The following items were not presently in the resident admission package:
2. j. Financial information including:
vi. Statement that residents are not required to purchase care, services, programs or goods from the home, and may purchase such things from other providers, subject to any restrictions by the licensee with respect to the supply of drugs
viii. Disclosure of any non-arm's length relationships between the licensee and other providers who offer care, services, programs or goods to residents

The General Manager confirmed that the following information had not been in the resident admission package. [s. 78. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

On August 19, 2014 during the tour of the drug destruction process with the DON a medication was found that was expired. Vitamin D in liquid form was found in the medication cart with an expiry date of June 2014. DON confirmed that the medication should have been removed and disposed of. [s. 129. (1) (a)]

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

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #005	2013_207147_0010	561
O.Reg 79/10 s. 50. (1)	CO #001	2013_207147_0010	561
O.Reg 79/10 s. 50. (2)	CO #002	2013_207147_0010	561
O.Reg 79/10 s. 50. (2)	CO #003	2013_207147_0010	561
O.Reg 79/10 s. 8. (1)	CO #001	2013_208141_0011	561
O.Reg 79/10 s. 90. (2)	CO #004	2013_207147_0010	147

Issued on this 14th day of November, 2014

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