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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 15, 2017	2017_640601_0011	007626-17	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 TAUNTON MILLS
3800 Brock Street North WHITBY ON L1R 3A5

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

KARYN WOOD (601), CRISTINA MONTOYA (461), DENISE BROWN (626), JENNIFER BATTEN (672), PATRICIA MATA (571)

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): May 1, 2, 3, 5, 8, 9, 10, 11, 12 and 15, 2017.

Critical incident Report (CIR) log #006666-17, log #034489-16 related to allegations of resident to resident abuse.

Critical incident Report (CIR) log #008928-17 related to allegations of staff to resident abuse.

Critical incident Report (CIR) log #033493-16, log #008412-17 related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Environmental Services, Environmental Service Worker, Neighborhood Coordinator (NC), RAI-Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist Assistant (PTA), Physiotherapist (PT), Kinesiologist, Family Council President, Resident Council President, residents and their families.

Also during the course of this inspection, the inspectors toured the home, observed meal service, medication administration, infection control practices, staff to resident interactions, resident to resident interactions, reviewed resident clinical health records, medication incident documentation, applicable policies, the Family and Resident Councils meetings minutes and the licensee's investigation documentation.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **2 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 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 were equipped with locks to restrict unsupervised access to those areas by residents and locked when they were not being supervised by staff.

On May 1, 2017, Inspector #672 observed eleven non-residential areas that were equipped with a coded panel lock on the door that did not restrict unsupervised access to those areas by residents.

Perry Neighborhood:

The door to the housekeeping room was unlocked and Inspector #672 was able to enter the room without using the code for the door panel. Inspector #672 observed a large fan blowing onto several wires that were connected to an electrical panel. There were multiple bottles of cleaning chemicals on the shelf in this room. The unlocked cabinet drawers contained cleaning chemicals, a pair of scissors and a hammer.

The door to the clean utility room was unlocked and Inspector #672 was able to enter the room without the using the code for the door panel. Inspector #672 observed razors, creams, lotions, perfumes and nail clippers.

The door to the laundry room was unlocked and Inspector #672 was able to enter the room. Inspector #672 observed an open container of powered laundry detergent stored under the counter.

Dryden Neighborhood:

The hair salon was unsupervised and Inspector #672 was able to enter the room. Inspector #672 observed multiple containers of chemicals and cleaners in this room.

The door to the soiled utility room was unlocked and Inspector #672 was able to enter the room without using the code for the door panel.

Claremont Neighborhood:

The door to the servery off the dining room was unlocked and Inspector #672 was able to enter the room. Inspector #672 observed cabinet drawers with three long sharp knives, scissors and Sannini Rinse cleanser. There was also a hot running water machine that was accessible and had no barriers in this room.

The door to the spa room was unlocked and Inspector #672 was able to enter the room without using the code for the door panel. Inspector #672 observed medicated treatment creams and cleaning chemicals in this room.

The door to the soiled utility room was unlocked and Inspector #672 was able to enter the room without the using the code for the door panel. Inspector #672 observed towels in the sleush bin that were soiled with feces in this room.

The door to the storage room was unlocked and Inspector #672 was able to enter the room without the using the code for the door panel. Inspector #672 observed razors, mouthwash, gloves, shaving cream, body cleansers, linens, and incontinent supplies in this room.

Dunlop Neighborhood:

The door to the spa room was unlocked and Inspector #672 was able to enter the room without using the code for the door panel.

The housekeeping room was unlocked and Inspector #672 was able to enter the room without using the code for the door panel. Inspector #672 observed store cleaners, soap and other hazardous chemicals on the shelves in this room.

Inspector #672 observed the Perry, Dryden, Claremont and Dunlop Neighborhood and identified that seven of the doors previously identified were still unlocked on May 5, 2017.

The doors identified on May 5, 2017 included the following:

Perry Neighborhood: Housekeeping room, clean utility room
Dunlop Neighborhood: Spa Room, Housekeeping Room, Utility Room
Dryden Neighborhood: Dirty Utility
Claremont Neighborhood: Spa Room was left propped open with the door stopper at the bottom of the door.

On May 1, 2017, the Assistant General Manager confirmed that the doors to all non-residential areas, such as the housekeeping and utility rooms are expected to be closed and locked at all times when staff are not present, as these rooms are not to be accessed by residents, for their safety.

On May 1, 2017, Inspector #672 showed the Environmental Service Manager the doors that were able to be opened without entering the code into the lock. He confirmed at that time the expectation was that these doors are to be locked at all times, and not accessed by residents, for their safety. He was planning on speaking with the staff, and reminding them of the importance of checking the doors once they are finished in the room, to ensure that the door handle was returned to the correct position, thus resetting the lock, and/or that the door stop had not gotten caught on the floor, causing the door to not close properly.

On May 5, 2017, Director of Care acknowledged to Inspector #672 that she had concerns about the non-residential rooms not locking properly, and she was working with the Environmental Service Manager to correct the issue. On May 5, 2017, the Environmental Service Manager stated he was working with the locksmith company to correct the problem, and they would be on-site following the weekend. In the meantime, he would be communicating with the nursing staff, and informing them of the concern, along with completing increased auditing of the non-residential doors, to ensure they are locked at all times, in an attempt to ensure resident safety. [s. 9. (1) 2.]

Additional Required Actions:

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

WN #2: 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 had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

On May 1, 2017, Inspector #672 observed the following:

Perry Neighborhood:

- Spa room with bathtub - There were two unlabeled urine collection hats; one on the back of the toilet and one on the floor. There was an unlabeled razor on the sink, and used, unlabeled hairbrushes with hair in them stored in the unlabelled bins.
- Shower room -There was one disposable razor on the counter, which was unlabeled, and appeared to have been used.

Dryden Neighborhood:

-Spa at the front of the unit - Unlabeled urine collection hat was on the back of the toilet. There were unlabeled, used hair brushes on the towel racks.

Claremont Neighborhood:

- In the Spa room - There was one used, unlabeled hair brush in the bin on top of the towel rack.

Dunlop Neighborhood:

- Spa Room - There were three unlabeled hair brushes on the towel rack, multiple

unlabeled electric razors sitting in the bin beside the sink, two unlabeled straight razors sitting on the paper towel dispenser.

The following observations were on the Dryden Neighborhood, made by Inspector #672:

May 2, 2017, in an identified room - There was an unlabeled urine collection hat on the back of the toilet.

May 2, 2017, in an identified room - There were unlabeled hair brushes and combs, with hair in them, sitting on the sink in this shared bathroom.

The following observations were made by Inspector #461, on the Claremont Neighborhood:

May 3, 2017, in an identified room - Noted unlabelled tubes of toothpaste on the counter in the shared bathroom.

May 3, 2017, in an identified room - There was an unlabelled bar of soap on the shared bathroom's sink.

May 3, 2017, in an identified room – Noted unlabelled toothbrush on the counter in the shared bathroom.

The following observations were made by Inspector #672, on May 5, 2017:

Dryden Neighborhood:

Shower room - There was a cardboard box sitting on the bench beside the tub, which had two pairs of unlabeled men's "Fruit of the Loom" underwear, and eleven pairs of unlabeled men's and women's socks.

Perry Neighborhood:

Spa room:

- There was an unlabeled "Phillips" electrical razor on the wooden shelf beside the bathtub, which appeared to be older and used.
- Unlabeled bottle of "ArjoHuntleigh" mouth wash on the wooden shelf beside the bathtub

- Unlabeled bottle of "Mary Kay" Satin Hands cream on the wooden shelf beside the bathtub
- Unlabeled jar of "Mary Kay" anti wrinkle cream on the wooden shelf beside the bathtub
- 2 unlabeled disposable razors, which appeared to have been used, on the wooden shelf beside the bathtub, in a white basket
- Unlabeled yellow loufa on the wooden shelf beside the bathtub

Shower room:

- Unlabeled "Speed Stick" roll on deodorant, which appeared to have been used
- Two unlabeled bottles of "ArjoHuntleigh" mouthwash
- Unlabeled bottle of "TENA" Soothing Cream

Dunlop Neighborhood:

Spa Room:

- Unlabeled urine collection "hat" on the back of the toilet

Shower Room:

- Unlabeled white loufa

Claremont Neighborhood:

Spa Room on left side of unit:

- Two unlabeled roll on "Lady Speed Stick" deodorant sticks, which were both opened and appeared to have been used
- Unlabeled yellow hairbrush with black bristles, with hair caught in it

Spa Room on right side of unit:

- Unlabeled black brush, with hair caught in it
- Unlabeled grey comb, with hair caught in it
- Unlabeled jar of "Nivea" body milk almond oil
- Unlabeled "Natural" roll on deodorant, which was opened, and appeared to have been used

- Unlabeled black comb which appeared to have been used
- Two unlabeled "Colgate" toothbrushes, which both appeared to have been used and were worn down
- Two unlabeled loufas - 1 yellow and 1 white
- Unlabeled jar of "Wellskin" barrier cream

During an interview on May 5, 2017 with Inspector #672, PSW #107 and #108 indicated that resident care items are to be labeled and stored in a labeled basket in each resident’s personal bathroom, and should never be stored in the spa and/or shower rooms. PSW #108 stated that personal care items should never be used between more than one resident. PSW #106 stated that the cardboard box which was noted in the shower room, with several pairs of unlabeled men's underwear, and multiple unlabeled pairs of men's and women's socks, was usually stored in the clean utility room, and was the unit's "Lost and Found", but that sometimes staff will take items from that box to use for residents, if they don't have any of their own items, such as socks.

During an interview with the Director of Care (DOC) by Inspector #672 on May 5, 2017, DOC confirmed that it is the home's expectation that all resident care items are to be individually labeled for resident use, and stored in the labeled basket within resident's bathrooms, not in the spa rooms.

The home has failed to ensure that each resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring. [s. 37. (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 each resident has their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's environment was safe and secure for its residents.

On May 1, 2017, Inspector #672 observed the following:

Perry Home Area:

The Kitchenette off the lounge area was open for resident usage. Inspector #672 observed some small objects such as paints and small beads in the unlocked cabinet drawer.

Claremont Home Area:

The Kitchenette/Green Room was open for resident usage. Inspector #672 observed a long sharp knife in the unlocked cabinet drawer.

Dunlop Home Area:

The Kitchenette/Green Room was open for resident usage. Inspector #672 observed utensils in the unlocked cabinet drawer.

Physio Room:

The Hydrocollator was turned on, and there was steam coming from the hot water located inside.

Fitness Club:

The Revlon Hot Wax machine was turned on and the hot wax was melted.

During an interview on May 1, 2017 at approximately 1325 hour, the Environmental Service Manager (ESM) indicated to Inspector #672 that residents had access to these common areas, the paints, small beads, sharp knife and utensils should all be stored in a secured area. The ESM also immediately removed these items from the resident common areas, when brought to his attention.

During an interview on May 1, 2017 at approximately 1645 hour, Inspector #601 observed the ESM take the temperature of the Revlon Hot Wax machine located in the Fitness Club and identified the temperature was 51.4 Degrees Celsius.

During an interview on May 1, 2017 at approximately 1700 hours, the Assistant General Manager (AGM) and the ESM indicated to Inspector #601 that the Physiotherapist was using the Revlon Hot Wax machine as a treatment for residents. During this same interview, the AGM indicated that the Revlon Hot Wax machine was not currently being used by the Physiotherapist to treat residents and the machine would be turned off.

On May 2, 2017 at approximately 1100 hour, Inspector #672 observed that the Hydrocollator and the Revlon Hot Wax machine were no longer located in the resident common areas. [s. 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the elevator was equipped to restrict access to areas that are not to be accessed by residents.

On May 1, 2017, Inspector #672 observed the following:

The home was equipped with two elevators, one on the right side of the building, and one

on the left. Each elevator required a code to be entered into the keypad, to call the elevator to service. The code for the keypad was posted outside of each elevator. By entering the code, the individual can then enter the elevator, and choose to go between the first and second floors. Within the elevator was another keypad, which required a code to enter the basement level. Inspector #672 entered the elevator, and entered that same code which was posted outside of the elevator into the keypad within the elevator. Inspector #672 was then able to access the basement level.

Once Inspector #672 entered the basement, the following was noted:

The main kitchen area was located in the basement.

The main laundry area was located in the basement.

The men's and women's locker room were both under construction, with large holes in the walls and floors, along with several areas of debris and hazardous conditions.

The staff room was located in the basement.

There was a door which accessed the back parking lot, which was not locked, and opened without a code or alarm.

There were three doors which lead to the underground parking lot, all were unlocked, and opened without a code or alarm.

There were three other doors which lead to stairwells, and then to exits to the outdoors. All doors opened without a code or alarm.

During an interview on May 1, 2017, the Environmental Service Supervisor indicated to Inspector #672 that the elevator code to the basement was the same as the first and second floor. During the same interview, the Environmental Service Supervisor indicated that some residents were aware of the elevator code and could potentially access the basement using the elevator. The Environmental Service Supervisor also indicated the basement was not always supervised and this area was not considered safe for residents.

Due to the home using the same code for the keypad within the elevator to access the basement level as the code posted outside of each elevator door, the home has failed to

ensure that the elevators were equipped to restrict access to areas that are not to be accessed by residents. [s. 10. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was easily seen, accessible, and used by residents, staff and visitors at all times.

On May 1, 2017, Inspector #672 observed the following:

Library on main floor - The call bell in this area was blocked by a large potted tree.

Fitness Centre on main floor - The call bell was a push button, which was located behind a computer on the computer desk. Although visible, the call bell was not accessible to residents due to the computer on the desk.

Dryden Home Area:

Fireplace lounge – The call bell was a push button, with no string, and the call bell was blocked by multiple unused wheelchairs.

Claremont Home Area:

Television area – The call bell was a push button and was blocked by a sofa.

Kitchenette/Green Room - The call bell was a push button and was difficult to locate due to being blocked behind a lounge chair.

Dunlop Home Area:

Spa Room - The call bell was a push button and was blocked with multiple pieces of equipment.

Fireplace Lounge - The call bell was a push button and was blocked by a sofa.

Kitchenette/Green Room - The call bell was a push button and was blocked behind a table.

The home failed to ensure that the resident-staff communication and response system was easily seen, accessible, and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #028 was taken to the hospital to assess an injury caused by an incident, the licensee was unable to determine within one business day whether the injury resulted in a significant change to resident #028's health condition, the licensee did not inform the Director of the incident no later than three business days after the occurrence of the incident.

Related to log #034489-16:

Inspector #601 reviewed Critical Incident Report (CIR) that was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date and time.

The CIR indicated that resident #028 was found on the floor in the resident's room and reported discomfort to an identified area. Resident #028's Physician was notified and ordered for the resident to be sent to the hospital for assessment.

Inspector #601 reviewed resident #028's progress note on the date of injury, RPN #138 documented that resident #028 was heard yelling from the resident's room and was found on the floor. According to the progress note, resident #028 reported discomfort to an identified area. The Physician was notified and resident #028 was sent to the hospital for assessment at this time.

Inspector #601 reviewed resident #028's progress note the day after the injury, RPN #137 documented that resident #028's Substitute Decision Maker (SDM) was contacted and reported that resident #028 had an identified injury and required a specific treatment.

During an interview on May 11, 2017, the Director of Care (DOC) indicated that resident #028 returned from the hospital twelve days after the injury and it was determined at this time that a significant change in the resident's condition had occurred. The DOC indicated that she was not aware of the significant change in the resident's condition until the resident returned from the hospital and the CIR was submitted upon the resident's return from the hospital. During the same interview, the DOC indicated that the MOHLTC should have been notified within three business days following the incident.

The Director was notified six business days following the incident. [s. 107. (3.1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #034 in accordance with the directions for use specified by the prescriber.

Review of the licensee's Medication Incident Report by Inspector #601 identified that on one identified date and time, Agency RN #136 did not administer resident #034's identified medication as prescribed by the physician. According to the Medication Incident Report, the error was discovered when the narcotic count was being completed. The Agency RN #136 reported the error to the Director of Care (DOC).

During an interview, the DOC indicated to Inspector #601 that Agency RN #136 had forgotten to administer resident #034's medication as prescribed by the physician.

Review of resident #034's Physician's Order Review by Inspector #601 identified that resident #034 was prescribed the identified medication twice a day.

Review of resident #034's Narcotic and Controlled Drug Administration Record by Inspector #601 for a three month period identified that on two identified dates and times resident #034 did not receive the identified medication as prescribed by the physician.

During an interview, the DOC indicated to Inspector #601 not being aware of the first medication incident and did speak to RN #132 by telephone after becoming aware of the medication incident. The DOC indicated to Inspector #601 that RN #132 had forgotten to administer resident #034's medication on the identified date prior to the second medication incident. According to the DOC, RN #132 discovered the medication omission on the identified date at change of shift. RN #132 indicated to the DOC that resident #034's Physician and Substitute Decision Maker were immediately made aware of the medication incident. During the same interview, the DOC indicated that RN #132 did not complete a medication incident report and did not document the medication incident in resident #034's progress notes.

On two identified dates and times, resident #034 did not receive a medication as prescribed by the physician. [s. 131. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed, analyzed and a written record was kept of the corrective action taken.

Review of resident #034's Physician's Order Review by Inspector #601 identified that resident #034 was prescribed an identified medication twice a day; the same medication was prescribed every four hours when needed.

Review of resident #034's Narcotic and Controlled Drug Administration Record by Inspector #601 for a three month period identified that on an identified date and time resident #034 did not receive the identified medication as prescribed by the physician.

Review of resident #034's progress notes by Inspector #601 for a three month period identified that prior to the medication incident being discovered, the Physiotherapist Assistant (PTA) #135 documented resident #034 had difficulty with physio exercises.

Review of resident #034's progress notes by Inspector #601 for the same three month period identified that on the same day in the late evening, RN #133 documented that resident #034's morning routine dose was not given and that at 1710 hour resident #034 received as needed medication for an identified discomfort with effect.

During an interview, the DOC indicated to Inspector #601 not being aware of the first medication incident and did speak to RN #132 by telephone after becoming aware of the medication incident. The DOC indicated to Inspector #601 that RN #132 had forgotten to administer resident #034's medication on the identified date prior to the second

medication incident. According to the DOC, RN #132 discovered the medication omission on the identified date at change of shift. RN #132 indicated to the DOC that resident #034's Physician and Substitute Decision Maker were immediately made aware of the medication incident. During the same interview, the DOC indicated that RN #132 did not complete a medication incident report and did not document the medication incident in resident #034's progress notes.

RN #132 discovered that resident #034 had not been given the 0800 hour dose of prescribed medication at approximately 1400 hour. At this time, RN #132 did not document the immediate action taken to assess and maintain the resident's discomfort. On the identified date at 1441 hour, PTA #135 documented that resident #034 was having discomfort. On the same day at 1710 hour, RN #133 administered resident #034's as needed medication for an identified discomfort. The DOC was not aware of the medication incident that occurred on the identified date and time involving resident #034 and the adverse drug reactions were not documented, reviewed, analyzed and a written record was not kept of the corrective action taken. [s. 135. (2)]

WN #9: 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 all staff participate in the implementation of the infection prevention and control program.

Inspector #672 observed that on May 1, 2017, two PSWs were providing the morning snack service on the Perry Home Area, and were not completing hand washing between assisting residents. Inspector #461 observed on the Claremont Home Area on the lounge area that on May 1 and 3, 2017, PSW #103, and on May 5, 2017, PSW #110 did not perform hand sanitization before starting the morning snack service, between assisting residents with feeding, and after PSWs' contact with residents' mobility devices. In interviews with PSW #103 and #110, PSWs indicated they were expected to wash their hands before starting the snack cart, when touching specific residents, before and after assisting a resident. There were no hand sanitizers on the snack carts, PSWs reported to use a hand sanitizer placed on the snack cart or the nursing station, both PSWs acknowledged that they did not follow the process for hand hygiene at the specified snack services. In an interview with the DOC about the Home's expectation for hand hygiene, the DOC indicated all staff are to follow the "4 Moments for Hand Hygiene" at all times.

The licensee has failed to ensure that all staff members participated in the infection control program. [s. 229. (4)]

Issued on this 16th day of June, 2017

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

Original report signed by the inspector.