Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## 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 |
|---|---|---|---|
| Jul 28, 2014 | 2014_225126_0019 | O-000666-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

LINDA HARKINS (126), AMANDA NIXON (148), AMBER MOASE (541), RENA BOWEN (549)

**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 16, 17, 18, 21, 22, 23, 24, 2014**

**The following logs were inspected:**
**Log #O-000769-13**
**Log #O-001147-13 cross reference with L0g # O-000819-13 Inspection # 2013_280541_0001**
**Log #O-001195-13**
**Log #O-000249-14**
**Log #O-000470-14**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Food Service Manager, the Office Manager, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers,two Activity Staff, the Nursing Clerk, the President of the Resident council, the President of the Family Council, several residents and several family members.**

**During the course of the inspection, the inspector(s) reviewed resident's health care records, staffing schedule for Registered Nurses and Personal Support Workers,the Resident Council minutes, the Narcotic count sheet for March 2014, reviewed the menus and food temperature logs, resident trust account information and several policies (medication, infection control, continence care) and observed care and services provided to the residents.**

**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**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**
**Trust Accounts**

**Findings of Non-Compliance were found during this inspection.**

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

**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:**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3(1)14., whereby the licensee did not ensure that every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

On June 17, 2014, Inspector #148 was speaking with Resident #13 in the resident's bedroom with the door closed. While speaking with resident Housekeeping staff #110 opened the closed door without knocking or in any other way acknowledging the resident's privacy. Staff #110 proceeded to hang clothes in the resident's wardrobe. A second Housekeeping staff member #109, entered the room, to distribute clothing. Neither staff member acknowledged the that the resident was in a private discussion with the Inspector. Due to the lack of privacy, Inspector #148, indicated to the resident that the discussion could be continued at another time, given that staff members were in the room.

On June 17, 2014, Inspector #148 was speaking with Resident #2 in the resident's bedroom with the door closed. While speaking with the resident, Housekeeping staff #109 opened the closed door without knocking or in any other way acknowledging the resident's privacy. When staff #109 entered the room and noted the presence of the Inspector, staff #109 turned to leave and closed the door.

On July 16, 2014, Inspector #148 was speaking with Resident #16 in the resident's bedroom with the door closed. While speaking with the resident, Housekeeping staff #110 opened the closed door without knocking or in any other way acknowledging the resident's privacy. Upon entry, Staff #110 was wearing his/her personal protective equipment and prepared to clean the room.

2. Housekeeping staff walked into resident 007's room while inspector was conducting an interview. Housekeeping staff # 110 went to resident's closet and put away the clothes and did not acknowledge that the resident was in a discussion with the Inspector and interrupted the interview. [s. 3. (1) 14.]

***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 every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, to be implemented voluntarily.***

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**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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 8. (1) in that the licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In accordance with O. Reg. s 114 (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home.

1) Inspector #549 observed the 08:00 am medication administration pass on July 22, 2014. RN #S100 and RPN #S107 where observed signing the resident's electronic Medication Administration Record (MARS) before the resident was given the medications. RN #S100 and RPN#107 indicated to Inspector #549 this is their regular practice to sign that the medication was administered before it is actually given to the resident.

Medical Pharmacies Pharmacy Policy & Procedure Manual for LTC Homes is the policy manual the home uses for the delivery of the Medication System.

Policy 3-6, Section 3, titled The Medication Pass dated 01/14
Under the section Procedure, Bullet #5: Check each medication label against MAR to ensure accuracy.
Bullet # 8: Administer medications and ensure they are taken
a) document on MAR in proper space for each medication administered or document by code if
medication not given.
b) for range of dose medications, document actual amount administered
c) document site of application or administration, if applicable.

On July 22, 2014 during an interview the Director of Care indicated to Inspector #549 that this is not an acceptable practice for the registered staff and that the registered staff is not trained to administer medications in this manner.

2) A Critical Incident Report was sent to the Director on a specific day of March 2014 related to missing medications.

On a specific day in March 2014 the DOC was notified in the afternoon that the narcotic count for a specific medication was missing 31 tablets for Resident #19.

On the previous day, on all three shifts, day, evening and night, the narcotic count sheet for Resident #19's medication was signed by two registered staff and the count was correct at 31 tabs.

The morning count of that specific day in March 2014, the narcotic count sheet for Resident #19's medication was signed by only one staff member (the night agency RN) that the count was correct at 31 tabs.

That specific afternoon in March 2014, the narcotic count sheet for Resident #19's medication was signed by two registered staff members that the count was not correct and there were 31 missing tablets.

The DOC stated to Inspector #549 during an interview on July 23, 2014 that when the

incident was investigated the day RPN stated the intent was to complete the narcotic count with the day RN on that specific day of March 2014 in the morning because the night RN left without counting with two registered staff but did not and when the count was completed with the evening RN the count was missing the 31 tablets of the medication.

The home's policy titled Extendicare Narcotics & Controlled Drugs dated December 2011 found in the Clinical Procedures Manual states in the second paragraph: two staff (one leaving and one coming on duty) must complete a narcotic count at the end/beginning of each shift. Any discrepancy in the narcotic/controlled drug count must be reported to the Director of Care immediately.

On July 23, 2014 the DOC indicated to Inspector #549 the practice of not completing the narcotic count by two staff(one leaving and one coming on duty) at the end/beginning of each shift as per the home's policy is unacceptable. (Log #O-000249 -14) [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 policy related to the medication administration pass and the narcotic count is complied with, to be implemented voluntarily.***

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**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).**

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**Findings/Faits saillants :**

The licensee failed to comply with O.Reg 79/10, s.37(1)(a), whereby the 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, labelled within 48 hours of admission and of acquiring, in the case of new items.

During the course of this inspection, it was observed that finger nail clippers for residents are stored in the shared resident tub room within a plastic unit with small individual drawers. Each drawer is labelled with the resident name, the nail clippers are not labelled. In addition, four unlabelled nail clippers were observed to be within three unlabelled drawers.

Unlabelled combs with visible hair, unlabelled toothbrushes and an unlabelled disposable razor with visible hair were also found within three resident shared bathrooms in the East wing.

Inspector #148 spoke with PSW staff members on July 23, 2014 who indicated that there is a process in place to label personal items in the home on admission. It was speculated by the staff members that some items may not always be labelled for new items that are acquired by resident's already residing in the home. [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 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, to be implemented voluntarily.***

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**WN #4: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 131. (1) in that the licensee did not ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On July 22, 2014 during the 08:00 am medication administration pass Inspector #549 observed RN #S100 give Resident #3 Lactulose Syrup 45 ml. Inspector #549 noted the bottle of Lactulose Syrup was labelled with Resident #18's name and directions for administration.

During an interview, RN #S100 and RPN #S107 indicated to Inspector #549 that this is their usual practice for administering Lactulose Syrup to all residents who have a prescribed order. Each resident has their own prescribed bottle of Lactulose with their name and directions for administration; the registered staff pours the liquid medication from the same bottle of Lactulose for all residents with a prescribed order until the bottle is empty then use another residents prescribed bottle until it is empty and continue to do this until all the bottles of Lactulose Syrup are empty.

On July 22, 2014 during an interview with Inspector #549 the Director of Care confirmed that the registered staff use one bottle of Lactulose Syrup labelled for a specific resident for all residents with a prescribed order. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.***

**WN #5: 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).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA c.8 s.6(1)(a) whereby the licensee did not ensure that the written plan of care for each resident that sets out the planned care for the resident.

On July 16, 2014, during stage 1 interview, resident #08 indicated that he/she has dentures and staff are cleaning the dentures on daily basis.

On July 21, 2014, resident #08 indicated to Inspector # 126 that staff in the evening will take the dentures and put it in a cup to let it soak for the night. Resident #08 indicated that the Personal Support Worker S#106 had brushed the dentures that morning. Resident #08 indicated that he/she had upper and lower dentures.

Discussion with S#106 indicated that resident #08 does have upper and lower dentures and requires assistance for brushing the denture in the morning. S #106 indicated that resident is capable of inserting the dentures independently.

The written plan of care was reviewed and include mouth care under hygiene but does not indicated that resident # 08 has upper and lower dentures and requires assistance twice a day to ensure that the dentures are clean. [s. 6. (1) (a)]

2. The licensee has failed to comply with LTCHA c.8 s.6(1)(c) whereby the plan of care does not set out clear directions to staff and others who provide direct care to the resident.

Resident #6 is identified on the current care plan as requiring total assist from staff to perform personal hygiene which includes mouth care. Resident's care plan states that resident requires assistance to brush his/her teeth. A "Quick Reference Sheet" is provided in resident #6's bedroom for direct staff to use while providing care. This sheet states resident has both top and bottom dentures.

During an interview on July 18, 2014, staff member PSW S#102 stated he/she thought resident had top dentures and was not sure if has bottom dentures or his/her own teeth. On July 21, staff member PSW S#111 stated that resident has her own bottom teeth and has top dentures. On July 21st staff member PSW S#106 stated that he/she provided resident #6's care that morning and resident #6 requires total assistance with mouth care and the resident has top and bottom dentures.

Resident #6 has top and bottom dentures and requires total assist for mouth care. Resident #6's care plan instructs staff to provide assistance to brush resident's teeth when resident has top and bottom dentures and requires total assistance. Resident #6's care plan does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

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**Findings/Faits saillants :**

The licensee failed to comply with O.Reg 79/10, 26(3) 8., whereby the licensee did not ensure that each plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

Resident #1 has an indwelling catheter that has been in place since at least early 2014.

The most recent Minimum Data Set (MDS) assessment indicates that the Resident was continent of bladder (use of indwelling catheter by definition) and incontinent of bowel with no change in the last 3 months. The most recent Resident Assessment

Protocol (RAP) for Urinary Incontinence/Indwelling Catheter indicated that the resident came back from hospital with a catheter and that the item will be care planned with the goal to ensure the resident is clean, dry and odor free, that skin will remain intact and no infection will develop related to the use of the catheter. Further to this, the RAI Coordinator reported to Inspector #148, that the resident no longer uses the toilet for bowel movements and uses incontinence products.

The health care record was reviewed with the home's RAI Coordinator. The health care record does not clearly indicate the reasons for the insertion of the catheter but physician notes indicate health conditions that may have contributed to the use of the catheter. Inspector #148 interviewed Registered Nurse staff #S100 and RAI Coordinator, neither staff member was able to describe the reasons for the catheter or the goals for catheter use and continence care.

The plan of care for Resident #1 was reviewed and it was demonstrated that there is no plan of care, related to continence or bladder and bowel elimination. The current plan of care for Resident #1 was not based on the interdisciplinary assessment. [s. 26. (3) 8.]

2. The licensee failed to comply with O.Reg 79/10, 26(3) 10., whereby the licensee did not ensure that each plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's health conditions, including risk of falls.

Resident #2 has a history of falls including three falls in the last nine months, two of the three falls related to self-transferring. The resident has visual impairment, previous stroke, requires assistance for ambulation and transfers and mobilizes with a wheelchair.

The Post Fall Assessment for the two most recent falls indicates the risk of falls was high. The most recent Minimum Data Set (MDS) Assessment includes a Resident Assessment Protocol (RAP) for falls which indicates the resident is on psychotropic medications and that a care plan will be put in place with the goal of no falls.

Inspector #148 spoke with PSW staff #S103, who was responsible for the residents care. The Staff #S103 reported that he/she was aware of that the resident has fallen in the past, but was not aware of the most recent fall that related to self-transferring. In addition, Staff #S103 did not identify the resident to be at risk for falls and did not

know of any care interventions in place to reduce the risk of falls.

The plan of care for Resident #2 was reviewed and it was demonstrated that there was no plan of care, related to the risk of falls. The current plan of care for Resident #1 was not based on the most recent assessments. [s. 26. (3) 10.]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, 51(2)(a), whereby the licensee did not ensure that each resident who is incontinent receives an assessment that includes the elements described by this provision and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #1 has an indwelling catheter that has been in place since at least early 2014. The health care record does not clearly indicate the reasons for the insertion of the catheter but physician notes indicate health conditions that may have contributed to the use of the catheter.

The Minimum Data Set (MDS) assessment in late 2013 indicates that Resident #1 was usually incontinent of bladder with no change in the last 3 months. The MDS assessment for early 2014 indicates that the Resident is continent (use of indwelling catheter by definition) with no change in the last 3 months.

It was confirmed by interview with the RAI Coordinator and the home's policy that the home has clinically appropriate assessment instruments for continence assessment and that a continence assessment should be completed 72 hours after admission and quarterly if there is a significant change in the level of either bowel or bladder incontinence.

The health care record was reviewed with the home's RAI Coordinator. It was confirmed that continence assessments are found under the Assessment tab of the electronic health care record. Upon review, a continence assessment for bowel had been completed for Resident #1 in the spring of 2014. A review of the health care record demonstrated that from late 2011 to July 18, 2014, no bladder continence assessment had been completed using the home's clinically appropriate assessment instrument. [s. 51. (2) (a)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s.68(2)(e)(ii), whereby the licensee did not ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

It was confirmed that resident weights and heights are documented within the resident's electronic health care records. Of the ten resident health care records reviewed, eight records were found to lack an annual recorded height measurement.

Inspector #148 spoke with the Director of Care and RAI Coordinator who both acknowledged that the home measures heights upon admission, however, the home does not measure heights annually thereafter.
[s. 68. (2) (e) (ii)]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

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

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**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s.85. (4)(a), whereby the licensee did not ensure that the satisfaction survey is made available to the Resident's Council anfd the Family Council, in order to seek the advice of the Council about the survey.

Inspector #126 interviewed Resident Council President on July 21, 2014. He indicated that the satisfaction survey results were not shared with the Family Council.

Discussion with the Administrator on July 22, 2014, indicated that he was under the impression that the results were made available with the Resident Council. The Resident Council minutes were reviewed for the periods of May 2013 until present and no documentation was found to indicate that the satisfaction survey results were made available to the Council. [s. 85. (4) (a)]

2. Inspector #126 interviewed the Family Council President on July 22, 2014. She indicated that she does not remember that the satisfaction survey results were made available to seek the advice of the Council.

Discussion with the Administrator on July 22, 2014, indicated that he was under the impression that the results of the survey were made available to the Council. The Family Council Minutes were reviewed with the Administrator and no documentation was found to indicate that the satisfaction survey was made available to the Council. [s. 85. (4) (a)]

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal**

**Specifically failed to comply with the following:**

**s. 136. (3) The drugs must be destroyed by a team acting together and composed of,**
**(b) in every other case,**
**(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and**
**(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg. 79/10, s. 136. (3) (b) in that the licensee did not ensure that where a drug that is to be destroyed is not a controlled substance, it will be done by a team acting together and composed of: i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii. one other staff member appointed by the Director of Nursing.

On July 22, 2014 during an interview with RPN #S107and RN #S100 it was indicated to Inspector #549 that the non-controlled drugs are not destroyed by a team acting together and composed of one member of the registered staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing and Personal Care.

RPN #107 and RN S#100 indicated to Inspector #549 that the present practice is to have a registered staff member acting alone put the non-controlled drug to be destroyed in a container in the medication room labelled non-narcotic drugs to be destroyed.

On July 22, 2014 during an interview with Inspector #549 the Director of Care confirmed with Inspector #549 that the present practice of the home when a non-controlled drug is to be destroyed it is done by one registered staff member acting alone. [s. 136. (3) (b)]

**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts**

**Specifically failed to comply with the following:**

**s. 241. (7) The licensee shall,**
**(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money received by the licensee from the resident, or any other person, for deposit in a trust account on behalf of the resident; O. Reg. 79/10, s. 241 (7).**

**s. 241. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).**

**s. 241. (11) The licensee shall make the results of the annual audit available to the Director on request. O. Reg. 79/10, s. 241 (11).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O.Reg 79/10, s.241(7)(a), whereby the licensee did not ensure that no more than $5,000 is held in a trust account for any resident at any time.

The Trust Statements for Resident #9 were reviewed for the last 12 months. The statements demonstrated that the account for this resident reached, and been maintained for several months, above $5, 000. The current balance as of July 21, 2014 is below $5,000. In an interview with the home's Office Manager staff #S105, it was reported to Inspector #148 that Resident #9 does not have a bank account outside of the home and that overpayments to the account have occurred. Staff #S105 reported that this may have contributed to the account being held at a sum above $5,000. [s. 241. (7) (a)]

2. The licensee failed to comply with O.Reg 79/10, s.241(8), whereby the licensee did not ensure that a resident who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of

the charge.

O.Reg79/10, s. 91 describes the legislative requirements for resident charges including accommodation and charges other than accommodations.

Resident #9, who manages his/her own finances, reported to Inspector #148 that in 2013 there was a withdrawal of an identified amount from his/her trust account held by the licensee. Resident #9 reported that he/she was not aware that the described withdrawal was to occur. The resident reported that he/she was only made aware of the withdrawal after having reviewed the following quarterly trust account statement. An interview with the home's Administrator and Nursing Clerk staff #S112, who was responsible for the trust accounts during the time of the withdrawal, indicated that the withdrawal was required as there had been inappropriate deposits made to the account. As described by the staff #S112 accommodation payments where withdrawal and mistakenly put back into the resident's account, leaving the resident in arrears. Staff #112 indicated that a discussion was had with the resident related the withdrawal prior to the date of the withdrawal. Upon request the home could not demonstrate that a written authorization for the withdrawal had been obtained. [s. 241. (8)]

3. The licensee failed to comply with O.Reg 79/10, s.241(11), whereby the licensee did not ensure that the licensee make the results of the annual audit available to the Director on request.

In accordance with O.Reg 79/10, s.241(1) and s.241(10), every licensee of a long term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident and every trust account established must be audited annually by a public accountant.

On July 22, 2014, Inspector #148 requested the annual audit of the trust account(s) held for residents of the home. The home's Administrator reported to the Inspector that the annual audit had been completed and that he would contact the corporate office to obtain a copy of the audit. On July 24, 2014, the final day of the inspection, the home had not yet been able to make the annual audit of the trust account(s) available to the Inspector. [s. 241. (11)]

**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** |
| LTCHA, 2007 S.O. 2007, c.8 s. 8. (3) | CO #001 | 2013_128138_0049 | 126 |

**Issued on this 29th day of July, 2014**

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