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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Oct 5, 2015	2015_342611_0010	T-001767-15	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 HUMBER HEIGHTS
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

KELLY CHUCKRY (611), CECILIA FULTON (618), LYNN PARSONS (153), SAMANTHA DIPIERO (619), SUSAN PORTEOUS (560)

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 10, 11, 12, 13, 14, 17, 18, 19, 20, and 21, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, the Registered Dietitian (RD), Dietary Manager, Neighbourhood Coordinators, Personal Support Workers (PSW's), Personal Care Attendance (PCA;s) housekeeping aides, dietary aides, laundry aides, and maintenance staff. A tour was conducted throughout the home during this inspection. Information was gathered through on-site clinical record reviews, interviews with residents, family members, and staff, as well as observations. In addition relevant home specific procedures were also reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

On an identified date, observations were completed of the morning medication passes on two resident home areas which revealed that used medication packets containing resident identification information and medication information are not disposed of in a way that protects the resident's personal health information.
Registered staff #111 revealed that the packets are put into a garbage bag attached to the medication cart, and from there that bag gets tied up and put in the soiled utility room with other garbage.
Housekeeping staff #112 revealed that the bag then gets added to other unit garbage and that from there it goes down stairs and gets added to a larger bin of general home garbage.
Maintenance staff #115 confirmed the processes describe is accurate. There was not further destruction of the packets that would render the personal health information unidentifiable.

The DOC indicated some registered staff submerge the used medication packages in water to dissolve the ink, thereby removing and protecting the personal health information of the resident, but advised that this practise is not universally done within the home.
Interview with the DOC confirmed the home does not have a policy in regards to the process for discarding used medication pouches. The DOC also confirmed the disposal of used medication pouches fails to ensure every resident has his or her personal health information kept confidential. [s. 3. (1) 11. iv.]

2. During an interview after directly observing medication administration for one resident, staff #104 advised that the packaging is discarded, that contains resident's personal health information in the garbage and was not aware of any policy regarding the correct disposal of medication packaging as expected by the home. Inspectors were able to confirm with the DOC that the home does not have a policy related to the destruction of medication packages. The DOC stated that some registered staff members submerge the used medication packages in water to dissolve the ink, thereby removing and protecting the personal health information of the resident, but advised that this practise is not universally done within the home. The licensee failed to outline a policy regarding the destruction of medication packaging that contains personal health information of residents and as such failed to maintain resident's confidentiality as it pertains to the Personal Health Information Privacy and Protection Act. The home did not meet the legislative requirement and was found to be non-compliant. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 are kept confidential in accordance with the Act,, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The Licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #003's plan of care indicated the RD ordered a nutritional supplement to be given three times a day on an identified date.
A review of the August Medication Administration Record (MAR) failed to reveal the nutritional supplement previously ordered for resident #003.
Interviews with registered staff #104 and the RD confirmed the order for the nutritional supplement had not been processed and as such resident #003 had not received the nutritional supplement as ordered.
Interview with the DOC confirmed the resident did not receive the care as set out in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care revised when the resident's care needs changed.

Resident #002 experienced a fall incident on an identified date, which resulted in the resident being transferred to hospital for assessment due to complaints of pain and a change in mobility status.
Review of resident #002's written plan of care indicated the resident uses a walker as a mobility aid on and off the neighbourhood.
Interviews with a registered staff #102 confirmed resident #002 is currently wheelchair dependent.
Observations conducted throughout the inspection indicated resident mobilizes with wheelchair only.
Interview with DOC confirmed the written plan of care had not been reassessed and revised when the resident's mobility needs changed. 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 the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that every resident is reassessed and the plan of care revised when the resident's care needs change, to be implemented voluntarily.

WN #3: 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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by resident's, and those doors must be kept closed and locked when they are not being supervised by staff.

On an identified date, a door leading to an inner corridor on an identified resident home area was found to be unlocked. Inside this corridor there was access to two rooms which were both without locks; these rooms house the linen chute and the housekeeping room which contained hazardous cleaning solutions that residents could have access to. This area led to a corridor which connected to another hallway where a roof access door was found unlocked. Further to that during the remainder of the home tour it was found that doors to the soiled utility rooms were unlocked which could give residents access to

hazardous cleaning solutions as well as electrical/cable panels.

On this date, 5 out 6 six balcony doors were observed to be unlocked and accessible to residents. During observations completed on specific dates, doors to the soiled utility rooms were noted as unlocked in addition to balcony doors.
On the same date, on an identified resident home area, it was observed that the Servery Door was unlocked; the door had a sign that read “Servery must be locked at all times”. This area of the home contained electric industrial food equipment and sharp food serving/preparatory utensils including a large serrated knife.
Interview held with Administrator confirmed that the home is required to lock the rooms located in the inner corridor on the identified resident home area. Interventions were put in place to prevent resident access to the balconies unless supervised. [s. 9. (1) 2.]

2. The licensee failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Access to outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access. It was observed that these locks were, on multiple occasions not employed, and as advised by the Administrator of the home the doors that lead to secure outside areas of the home including balconies and terraces are generally left unlocked and residents are able to access these areas with minimal supervision. The policy provided by the Administrator titled “Safe Outdoor Living", revised October 2014, fails to specifically address this legislation. The Administrator of the home confirmed that the home's policy did not meet the legislative requirement. The home's policy does not specifically outline when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. Interview held with Administrator confirmed that the doors to the balcony should be locked when residents’ are unable to be supervised on the balcony by staff. The Administrator advised that she would follow up at the corporate office to address the policy and make changes to it so that it meets the legislative requirement. [s. 9. (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 resident's, and those doors must be kept closed and locked when they are not being supervised by staff and ensure there is a home policy associated with this, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the following requirements for use of a Personal Assistance Service Device (PASD) have been met in accordance with the legislation.

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.
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.
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.

Record review of resident #004's health records and an interview with staff #118 revealed that the assessment named PASD1,2 – Alternatives to PASD/Restraint Assessment for this resident was not completed with regards to use of bed side rails. Record review further reveal that no consent has been obtained from the resident or their SDM for use of this PASD.
These findings were confirmed during an interview with staff member #118. [s. 33. (4)]

2. Record review of resident's health records and interview with staff #128 revealed that resident #006 required the use of side rails for the purpose of repositioning and was identified as a Personal Assistance Service Device (PASD). Consent had not been obtained for the use of this device. Registered staff #128 confirmed the consent was not obtained. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements for use of a PASD are met in accordance with the legislation.
Section 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.
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. Specifically, the home must ensure that assessments are completed to ensure the use of alternatives to PASD's. In addition, the home must ensure that consent is obtained before a PASD is put into place, to be implemented voluntarily.

WN #5: 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 has failed to 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.

Resident #004 sustained falls on three identified occasions. There were no post fall assessments able to be located for two of the identified dates.
Interviews with staff #127, #128 and #118 confirmed that after each fall staff is to complete a Falls incident report and a Post falls follow-up. Staff #127 and #118 confirmed that there were no falls incident reports nor post fall assessments completed for the two falls that occurred on the two identified dates. [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 a resident has fallen, the resident is assessed and that when 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years were posted in the long term care home.

On August 10th, 2015, during the initial tour of the home a licensee copy was noted to be posted for the Resident Quality Inspection #2015_250511_0001. A review of the home's compliance history revealed a complaint inspection numbered 2014_235507_0012 dated June 6th, 2014, and a second complaint inspection numbered 2013_159178_0027 dated November 28, 2013 were not posted as required. An interview was conducted with the Administrator of the home to enquire if the home had received the public inspection reports for posting. Upon request from inspectors the Administrator confirmed that the posted inspection report was the Licensee's copy and not the public report and that the other two inspection reports dated June 6th, 2014 and November 28th, 2013 were not posted for public viewing. On August 13th, 2015, inspectors observed that the three public copies of the Licensee's inspection reports were posted in the home for public viewing. [s. 79. (3) (k)]

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 copies of the inspection reports from the past two years are posted in the long term care home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

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

On an identified date during the initial tour of the home it was determined that the door adjacent to the elevator on an identified resident home area was unlocked. Upon entry into the small hallway it was observed that one of the two rooms located inside was the housekeeping room which did not have a lock mechanism on the door.
Inside this housekeeping room inspectors observed several chemicals that could cause harm to residents; these chemical solutions are noted below:
-Woodwant Stainless Steel Cleaner
- Diversey Red Juice stain remover
- Diversey Protein potter
- Diversey General Purpose cleaner
- Diversey Tannin Stain remover
- Diversey Gum Remover
- Finish Powerball Quantum max
-Alpine Cyclone detergent
-Shower/tile/ cleaner
The labels on the cleaners indicated users to not ingest as they are harmful if swallowed, and that they may cause skin and eye irritation.

Interview with the Administrator confirmed the door to the inner hallway should be locked to prevent residents from accessing this area. The home installed a new lock leading to the inner hallway once notified by the inspector. [s. 91.]

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 hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #040 has a current order in place to self administer eye drops as directed. These eye drops were found in the resident's bathroom on the counter. The eye drops ordered for resident #040 were not stored in a secure area.
Resident #040 did not have a current order to self medicate topical prescribed medicated creams. This resident had four (4) jars of medicated cream in the washroom on the counter. These medicated creams were not stored securely in an area or a medication cart. The Director of Care (DOC) confirmed it would be the home's expectation to ensure that eye drops and medicated topical creams be stored in a secure area if ordered to self medicate or in a medication cart.

Resident #041 was found to have two jars of medicated topical creams in a care caddy in resident #041's bathroom. These medicated treatment creams were not stored in a secure and locked medication cart. The DOC confirmed it would be the home's expectation that medicated topical creams be stored in a secure and locked medication cart. [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies.

On an identified date on a resident home area, the Inspector observed a wallet, an envelop containing money and several jewellery items locked in the narcotic storage area of the medication cart.
An interview with the DOC confirmed these items are not drugs or drug related items and should not be stored in the medication cart. [s. 129. (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 drugs are stored in an area or a medication cart, ii. that is secure and locked, to be implemented voluntarily.

WN #9: 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 residents in accordance with the directions for use specified by the prescriber.

On an identified date, a physician order was received for resident #005 for a topical medicated treatment cream to be applied twice a day for a skin condition. A review of the treatment administration record (TAR) failed to contain this physician order. As confirmed by registered staff #110 this order had not been transcribed or administered. A further review of the TAR indicated a topical treatment order for a medicated treatment cream to be applied three times daily to legs. This treatment cream was discontinued without a physician order. Interview with registered staff #110 confirmed this order was discontinued in error.
An interview with the DOC confirmed the home's expectation is that drugs will be administered in accordance with directions for use by the prescriber and in this situation a medication error had occurred. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #10: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.
Review of the home policy titled "Wound/Skin Care" #04-78, revised January 9, 2015 indicated the following:
4. On an ongoing basis, the PCA will complete the Skin Assessment, typically on each bath day, and record on the Resident's Flow Sheets if no concerns need to be addressed. If there is a concern, it will be documented using the Twice Weekly Skin Assessment Form (see page 9) and a Skin Assessment Concerns Form (see page 10) will be completed and given to the Registered Team member.
Record review and staff interviews failed to reveal that the twice weekly skin assessments were completed for resident #005 who exhibited altered skin integrity. Staff #126, who is recognized as the Skin and Wound lead, and staff #118 confirmed that twice weekly assessments had not been completed as per their policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system regarding medication destruction was complied with.

The home's policy titled "Disposal of Discontinued Medications" index number 02-06-20, last updated June 23rd, 2014, states that narcotic and controlled substances to be destroyed are to be stored in a double locked storage area within the facility, separate from any narcotic and controlled substance available for administration to a resident. On an identified date on an identified resident home area, an observation of the narcotic storage area was completed. During the observation a registered staff #004 identified a narcotic medication card containing 11 tablets for resident #024 who no longer resided in the home.
An interview with the Director of Care confirmed this resident previously passed away, leaving the medication intact and not removed for destruction from the available supply of narcotics drugs for residents for a period of 43 days. The Director of Care confirmed that it is the home's expectation that medication no longer in use must be destroyed in a timely fashion and that this was not done for the medication in question. [s. 8. (1) (b)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On an identified date, during an initial tour, Inspector #619 observed an area of carpet in the hallway outside a resident room on an identified resident home area in disrepair. Approximately 4 feet of carpet was able to be lifted from the floor and posed a potential trip hazard.
The potential trip hazard was reported to the Administrator who confirmed the carpet was in disrepair and notified maintenance staff who immediately repaired the carpet. [s. 15. (2) (c)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the Residents' Council meeting held on July 16, 2015, the following concerns were raised:
- not enough sweets on the snack menu
- more reminders needed regarding upcoming events and programs
A written response was not received by the Residents' Council until fifteen days after the initial concern regarding insufficient sweets on the snack menu and seventeen days regarding the need for additional reminders of upcoming events and programs.
Interviews with the Residents' Council assistant and the Administrator confirmed a written response was not received by Residents' Council within 10 days of receiving the concerns. [s. 57. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, communication of the seven-day and daily menus to residents.

On an identified date, during lunch meal service on an identified resident home area an observation took place. This observation revealed the weekly menu cycle, including snack menu for the current week was not displayed. An identified dietary aide confirmed the current weekly menu and snack menu was not displayed as a form of communication for residents. [s. 73. (1) 1.]

2. On an identified date observations of residents dining during lunch meal service on an identified resident home area revealed the weekly menu cycle and including snack menu for the current week was not displayed. Interview with Dietary Manager stated the weekly menu cycle is expected to be posted for communication to residents each Monday and further confirmed the weekly menu for current week two (2) had not been posted and that snack menus are not displayed for communication to residents. [s. 73. (1) 1.]

3. The licensee failed to ensure that the furnishings in the resident dining area, specifically the tables, are at an appropriate height to meet the needs of all residents.

Observations completed on an identified date on an identified resident home area revealed resident #023 was seated too low at the table for the lunch and dinner meals. The table heights in this dining room were non-adjustable.
When seated in the wheelchair at the table the resident was forced to reach upwards to gain access to meal in order to feed self.
Interview with resident indicated the table was too high and the resident was unable to see the plate or food in order to feed self.
Interviews with Kinesiology staff #130 confirmed the resident has a history of sitting low in the chair and there had been no adaptive devices implemented to assist the resident during meal times.
Once the issue was brought forward the Kinesiology staff member #130 indicated a referral would be initiated and an assessment would be completed. [s. 73. (1) 11.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council, if any, in the carrying out of the satisfaction survey.

The licensee annually conducts a residents/family satisfaction survey in the home. This survey is distributed in the home and made available to residents and copies are also mailed to resident families for input as well. A review of the 2014 Residents' Council meeting minutes revealed the annual survey results were shared with the Residents' Council on July 17, 2014. There was no information identified to indicate the licensee sought input from the Residents' Council for input in regards to the manner the annual survey would be carried out.
Interviews with the Residents' Council assistant and Administrator confirmed the home did not seek the advice from the Residents' Council in regards to the manner in which the survey is carried out. [s. 85. (3)]

WN #15: 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 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.

Resident #040 had an order for a medicated topical cream be applied to a specific area for a period of fourteen (14) days. The last dose of this medicated treatment cream was identified as a specific date. This treatment cream was not destroyed at the completion of the last dose. Staff member #114 confirmed this medicated treatment cream should have been destroyed after the last dose.

Resident #041 had an order for a medication topical cream be applied until clear. An identified staff member #114 confirmed the area was clear and the treatment cream was not destroyed.

The Director of Care confirmed these medications should have been destroyed. [s. 136. (3) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, resident #042 and resident #043 were observed to have unlabelled personal hygiene items in their shared respective washrooms. In addition, resident #043 was observed to have unlabelled personal hygiene items at the bedside. Staff #014 confirmed these items should be labelled. The DOC confirmed it would be the home's expectation to label all personal hygiene items for residents who share washrooms and/or bedrooms with co-residents. [s. 229. (4)]

2. On an identified date during the initial tour of the home a total of five home areas were observed to have unlabelled used personal hygiene products in the Spa Shower and Spa Tub rooms. In an identified resident home area, unlabelled used deodorant and unlabelled nail clippers were identified. In another identified resident home area unlabelled used combs and hair brushes, unlabelled manual razors as well as unlabelled nail clippers were identified. On another identified resident home area unlabelled manual razors, nail clippers, and hair combs were identified. On another identified resident home area unlabelled hair combs, used unlabelled deodorants, a commode bowl stored on the floor and used manual razor were identified in addition to hair and other debris identified in the spa tub. On another identified resident home area a soiled incontinent brief left on the spa shower room floor was identified. Unlabelled used personal hygiene items were identified on an identified resident home area on an identified date. Housekeeping staff confirmed that these items should be labelled in accordance with the homes infection prevention and control policy. The DOC confirmed it is the home's expectation to ensure these items are properly labelled. [229. (4)]

3. The licensee has failed to ensure that on an identified date the inspector observed the medication pass at 1130 hrs on an identified resident home area. The medication nurse staff #119 was observed to not perform hand hygiene procedures between residents # 010, #011, #012 and #013 while administering oral and injectable medications along with the completion of glucometer readings.
Interview with staff #118 confirmed the hand hygiene is to be performed during resident medication administration. [s. 229. (4)]

Issued on this 13th day of November, 2015

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

Original report signed by the inspector.