1. The resident-staff communication and response system could not be easily seen, accessed and used by residents, staff and visitors at all times.

A) Resident #5001 reported that the call bell in their bathroom did not always work when attempted to activate the bell. The resident indicated that when staff cancel the bell at the point of activation, the bell did not consistently reset and therefore it may not be used by the resident. On May 21, 2013, at 1030 hours in the presence of the resident and family, the inspector attempted to activate the bathroom bell however, it could not be activated to alert staff.
B) The call bell activation stations in various resident ensuite washrooms were located beyond the reach of residents when using the toilet. The home had instituted a longer call cord for most of these washrooms which extended towards the toilet and within reach of the resident. The washrooms in nine rooms were observed to have call bell cords that were either on the floor, hanging down behind furnishings or coiled up onto the activation station, making it difficult to access. [s. 17. (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 the resident-staff communication and response system may be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. Not all staff used all devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Resident #4008 was observed on April 29, 2013, at 1050 hours, in the lounge area wearing a loose fitting front closing seat belt, which they were able to unfasten on request. The belt was applied loosely, with a distance of approximately 6 inches between the resident's abdomen and belt when pulled forward. Two staff interviewed were unable to identify the manufacturers' specifications regarding the application of the belt, specifically how loose or tightly to apply the device. The DON confirmed that education was completed August 13, 2012, which included how to apply a seat belt, with just enough space between the belt and the pelvic crest. Staff did not apply the device according to the instructions. [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all devices in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The policy and procedure related to the use of physical restraints was not complied with.

Policy "NUR-POL/10 titled, Restraints, PASD's, and Alternatives, last reviewed on May 10, 2011", required staff to complete an assessment each time a restraint/PASD was re-ordered, for each type of device in use. Interview with DON and ADON confirmed that each time a device was re-ordered, including during quarterly medication reviews that the assessment be completed to determine if the device was still required by the resident.
A) On May 1, 2013, resident #4000 had a new order written for a seat belt when in the wheelchair. The consent form signed on May 2, 2013, identified the device used was a restraint. There was no assessment completed, as of 1300 hours, on May 7, 2013, regarding the use of the belt. The last assessment completed, specifically related to positioning aids was in December 2012, for the use of a tilt wheelchair for positioning. Staff interviewed confirmed that all assessments specific to restraints would be completed electronically when the device was ordered.
B) Resident #0883 had an order for a seat belt while up in the wheelchair. Documentation confirmed that consent was obtained from family to support the use of the seat belt as a restraint. The resident had a restraint assessment completed July 25, 2012, however did not have another restraint assessment completed until January 21, 2013. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy and procedure related to the use of physical restraints is complied with, to be implemented voluntarily.

WN #16: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

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. Not all Personal Assistance Service Devices (PASD) described in subsection (1) were used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Review of the home's "Restraints, PSADs and Alternatives policy, NURSING - NUR-POL/10 last revision date May 10, 2011" confirmed that bed rails can be considered as a PASD if used for bed mobility and positioning.
Resident #9743 was observed on April 28, 29 and May 1, 2013, to be in bed with two half rails up. The resident confirmed use of the rails to assist with mobility in bed. Staff confirmed the use of the two half rails to assist the resident to turn and position. The current plan of care, last reviewed on February 3, 2013, did not include the use of bed rails that were considered to be a PASD. [s. 33. (3)]

2. Not all of the following were satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD considered, the use of the PASD was reasonable given the resident's condition, consent had been obtained and the device was approved.

Resident #9743 used two half rails when in bed as a PASD to assist with bed mobility. The health records did not include an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the registered staff and the RAI Co-ordinator confirmed an assessment was not completed prior to the application of the PASD. The record did not include the approval of the PASD by an appropriate person as defined in the legislation nor was consent documented as being obtained from the resident for the use. [s. 33. (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 PASD's are only used as permitted in the legislation, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The interdisciplinary skin and wound care program was not consistently implemented in the home.

A) The directions on the Bath Day Skin Assessment, which was part of the skin and wound care program, indicated that residents were to have their skin examined during the first bath of the week and should include all altered skin integrity. Discussion with nursing management confirmed that all areas of altered skin integrity should be recorded on the assessment tool. The assessment for resident #0015 for April 6, 13 and 16, 2013, was signed as "no problems noted" however, the resident had a wound during this period of time.
B) The skin and wound care program required staff to assess the resident with new pressure or stasis ulcers using the Bates-Jensen Wound Assessment and then complete the tool weekly until healed. Resident #0015 had a wound develop on September 29. 2012. From September 29, 2012 until April 30, 2013, the Bates-Jensen wound assessment tool was not completed for the resident's wound for 22 of the 30 weeks. [s. 48.(1)2.]

The interdisciplinary pain management program was not consistently implemented in the home.

A) The policy "Pain Management, Nursing NUR-POL/12, last reviewed May 3, 2013" identified weekly assessments were to be completed where pain medications were prescribed routinely or as needed. The registered staff would indicate the Numerical Rating Tool score (NRT) or Abbey Score on the MAR on day and evening shifts, and record the findings once that day in the progress notes.
i) Resident #9743 MAR for April 2013, were reviewed. The resident had been on an analgesic every 72 hours since 2012 and extra strength tylenol when needed. On April 9, 16 and 30, 2013, there was no documentation of pain scores for the evening shift and on April 22, 2013, there was no pain score for the day shift and no documentation in the progress notes.
ii) Resident #9863 MAR for April 2013, were reviewed. The MAR documentation indicated weekly assessments for pain were to be completed on April 3, 11, 17 and 24, 2013. There was no documentation in progress notes of the weekly pain assessment for April 17, 2013. On April 11 and 17, 2013, there was no documentation of pain scores for the evening shift. On April 24, 2013, there was documentation of pain score for the day shift.
iii) Resident #6011 MAR's for April 1 until May 8, 2013, were reviewed. The resident

was receiving a narcotic every three days and a second analgesic as required, which was administered seven times during the time period. Pain assessments were identified in the MAR to be completed on April 4, 11, 18 and 25, 2013 and May 4, 2013. There was no documentation in the progress notes for April 4 and 11, 2013, or May 4, 2013, related to a pain assessment. Documentation of the pain score was not in the MAR or progress notes for the evening shifts April 4 or 25, 2013.
iv) Resident #2001 did not consistently receive a weekly pain assessment by registered staff, indicating the score recorded on the MAR on days and evening shifts, or findings documented once each day in the progress notes. During the month of April 2013, two out of five times, the MAR indicated the assessment was not completed during the day shift. Supporting progress notes were not completed for the time period, which was confirmed by registered staff.
B) The policy "Pain Management, Nursing NUR-POL/12, last reviewed May 3, 2012" identified new orders/newly identified/reported pain would be assessed twice daily for a period of five days to determine the pain level and effectiveness of interventions. The scores would be recorded on the MAR, findings documented in the progress notes and care plan interventions would indicate evaluations with the physician on the next visit as a re-evaluation of the pain management program.
i) Resident #9863 was identified with a fracture, after an unwitnessed fall. The resident articulated increased pain for which they received pain medication as required. The MAR, did not include documentation of daily pain scores for five days following the new pain being identified and the progress notes did not have consistent documentation of findings related to the scores and effectiveness of medication. [s. 48. (1)]

2. The continence care and bowel management program to promote continence and ensure that residents were clean, dry and comfortable was not developed and implemented in the home related to section 51(1) of O. Reg. 79/10, regarding treatments and interventions to prevent constipation, including nutrition and hydration protocols.

The home's Continence Care and Bowel Management Program indicated that on day one with no movement staff were to encourage fluids, on day two natural stimulants were to be offered, on day three a natural stimulant in the morning and a laxative were to be offered, on day four a suppository would be offered. If the resident did not have any results from the suppository the staff would complete an abdominal assessment, rectal check and contact the physician for further direction.

A) Resident #0883's Bladder Function and Bowel Movement Chart for February 2013, identified no bowel movement from February 21, until February 25, 2013. The MAR and progress notes indicated the resident received a suppository on the fifth day with no bowel movement however; staff confirmed that there was no treatments provided prior to February 25, 2013. The March 2013, bladder function and bowel movement chart indicated the resident did not have a bowel movement between March 14 and 19, 2013. Registered staff confirmed that if interventions were provided that documentation would be completed on the MAR and progress notes. The MAR and progress notes confirmed there were no treatments provided to assist the resident during this time. The resident did not have a bowel movement between March 25 and 28, 2013. The resident received a suppository on the fourth day however; the MAR and notes confirmed no other treatments were provided by staff.
B) The January 2013, Bladder Function and Bowel Movement Chart, for resident #0986 indicated no bowel movement between January 21 and 25, 2013. Documentation in the MAR and progress notes confirmed that the resident received treatments on the second and third day with no bowel movement however; registered staff confirmed that the resident did not receive a suppository until the fifth day with no movement. There was no evidence in the clinical record that an abdominal assessment or rectal check was completed during this time. [s. 48. (1) 3.]

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 skin and wound care program, continence care and bowel management program and pain management program are consistently implemented, to be implemented voluntarily.

WN #18: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Not all residents who were unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

According to the progress notes, during a specific night shift resident #4007, who required assistance of two staff to toilet, called and requested assistance to the commode to have a bowel movement. At the time of the call there was only one staff available on the unit to assist in the provision of care for the resident. The resident was incontinent of a small amount of stool in the incontinent brief before being cleaned by staff. Staff confirmed that on nights there was one PSW assigned to the unit and that the staff worked with a co-worker, who was on the other side of the floor, or the RPN, who covered multiple home areas, when residents required more than one staff to provide care. [s. 51. (2) (c)]

2. Not all residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

Resident #9925, required assistance with continence care, used an incontinent product, had a history of responsive behaviours and was unable to make own care decisions. Progress notes dated in early 2013, identified that the resident was resistive to care for the previous two shifts and that on the third shift, when care was accepted the resident was in a brief that was heavily soiled with urine. A second progress note a few months later, identified resistance to care the two previous shifts, however when care was provided, on the third shift, the brief was wet with hardened feces stuck to the resident's skin. The plan of care, created on January 23, 2013, and updated on April 24, 2013, identified the resistance/refusal of care however also indicated that if refusals continues and care needs to be provided two staff may be needed. [s. 51. (2) (g)]

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 residents who are unable to toilet independently receive assistance from staff to manage and maintain continence and that residents have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #19: 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).

Findings/Faits saillants :

1. The program did not include a weight monitoring system to measure and record with respect to each resident, weight consistently on admission and monthly thereafter.

A) Resident #5000 did not have weights taken and recorded monthly in Goldcare for February 2012, April 2012, August 2012, September 2012, October 2012, December 2012, January 2013, February 2013 and March 2013. The RD confirmed that the process was for staff to obtain the resident's weight and record it in Goldcare. The RD indicated that weights were not consistently taken and recorded each month for the resident.
B) Resident #5004 did not have weights taken and recorded monthly in Goldcare for January 2012, June 2012, August 2012, October 2012, November 2012 and December 2012. [s. 68. (2) (e) (i)]

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 program includes a weight monitoring system to measure and record with respect to each resident, their weight consistently on admission and monthly thereafter, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. Not all residents were assessed using an interdisciplinary approach, nor were actions taken and outcomes evaluated when the resident experienced a significant weight loss.

Resident #0883 weight recorded on December 17, 2012, was a six kg decrease from the October 2012 weight. There was no recorded weight for November 2012. The RD confirmed that there was no assessment completed using an interdisciplinary approach. The resident had been receiving a nutritional supplement since February 23, 2012, however; actions were not taken nor current interventions evaluated despite a significant weight loss in December 2012. [s. 69.]

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 residents are assessed using an interdisciplinary approach, and actions taken and outcomes evaluated when the resident experiences a significant weight loss, to be implemented voluntarily.

WN #21: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The dining and snack service did not include a review of the the meal and snack times by the Residents' Council.

Interview with the President of Residents' Council and the FSM and a review of the meeting minutes for 2012 and 2013 confirmed that the dining and snack service did not include a review of the meal and snack times by the Council. [s. 73. (1) 2.]

2. Not all residents who required assistance with eating or drinking were served a meal until someone was available to provide assistance required by the resident.

A) Resident #5002 was served soup April 22, 2013, prior to 1240 hours however; a staff member was not available to provide feeding until 1255 hours. The resident was then fed the soup, entrée and dessert by staff as directed by the plan of care.
B) On April 22, 2013, residents #4000, #4002 and #4003, who were all identified at high nutritional risk, were not served a meal only when someone was available to assist them. All three residents had their soup, entree and dessert at the tables by 1300 hours, however staff did not begin to assist/encourage the residents until 1321 hours, 1311 hours and 1323 hours. Staff interviewed identified that the residents required some assistance with eating and that it was the practice to serve meals to all residents in the dining room, at the same time, even if assistance would be delayed. Plans of care confirmed that the residents required some assistance with eating.
C) Resident #5003 was served soup, however had no initiation of self feeding and no encouragement from staff. At 1210 hours, the entree was served and the resident sat for 23 minutes with no encouragement or initiation to feed themselves. At 1233 hours, a staff member, who had just completed feeding another resident, started to feed the resident. The resident ate when fed. The plan indicated the resident required plus encouragement and sometimes staff were required to feed. The resident was served the meal before staff were able to assist. [s. 73. (2) (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 all residents who require assistance with eating or drinking are served a meal only when someone is available to provide assistance required, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Procedures had not been developed or implemented for the cleaning of the home.

A) A tour of all serveries and kitchens was conducted and the following identified:
i) Flooring surfaces in all kitchens were observed to be dirty (black).
ii) Lower cabinet surfaces were visibly splattered in most serveries.
iii) Wall surfaces in most serveries where food carts stored were soiled.
iv) Top surfaces of refrigerators were dusty/dirty in most serveries.
v) Dead insects were identified in light covers in three kitchens and or serveries.
vi) Debris was located under the fixed tables in most kitchens, under the corner sinks.
B) On April 25, 2013 the fridge located in the second floor North Tower medication room used to store insulin, supplements and suppositories, was observed to be heavily soiled with spilled liquids and loose debris was noted on the bottom of the fridge.
Interview with the staff member confirmed that the fridge was not cleaned routinely.
C) Resident ensuite washrooms, tub/shower rooms, soiled utility rooms and other rooms were all connected to a central exhaust system. The exhaust grilles in each of these rooms were noted to be heavily laden with dust on the inside. Maintenance staff confirmed that these individual grilles have not been scheduled for routine cleaning and no procedures have been developed for exhaust system cleaning. [s. 87. (2) (a)]

2. Procedures had not been developed or implemented for the cleaning of care equipment and supplies and devices.

A) A heavily soiled wheelchair was observed in a dining room on May 1 and May 7, 2013. The chair was labeled with the name of a former resident. Staff reported the chair was used by a resident only during meals. The chair had not been placed on a cleaning routine, like the other chairs belonging to current residents.
B) Bed pans, urinals and basins were not cleaned and disinfected after each use as required to prevent the transmission of disease causing organisms.
i) Soiled bed pans and/or urinals were observed in three resident ensuite washrooms on May 1, 2013. On May 7, 2013, the same soiled articles remained in the same locations with the same stains and markings. When cleaning logs were reviewed, staff signed off that these articles were picked-up and cleaned on May 1, 2 and 4, 2013.
ii) On May 7, 2013, a PSW was observed in a room using a basin for resident care. The PSW rinsed the basin and returned it to the resident's bathroom cabinet.

iii) The home had a schedule requiring staff to deep clean urinals and bedpans once per week, instead of after each use. According to Public Health Ontario's best practices documents titled "Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, February, 2010", and "Routine Practices and Additional Precautions in All Health Care Settings, November, 2012", re-usable non-critical medical devices such as bed pans, urinals and washbasins require cleaning and disinfection between use.
iv) No schedule was identified for washbasin cleaning. [s. 87. (2) (b)]

3. There were no procedures implemented for addressing incidents of lingering offensive odours.

A) A home area an April 22, 2013, at 1055 hours, 1230 hours and April 24, 2013, at 1150 hours, was noted to have lingering offensive odours in the lounge.
B) Offensive and lingering odours were identified on second home area on a number of days during the inspection. Staff identified that some residents on the unit have responsive behaviours which include inappropriate voiding. Urine odours were strong outside of a specific room, in the corner of the corridor, where two chairs and a table were. The home area was carpeted in the corridors and the carpet was not steam cleaned as needed. The carpets were cleaned by an external contractor who rotates between 14 home areas over the course of a month. The PSW's were able to detect where urine was left behind however were unable to adequately extract the urine with the supplies on hand. Housekeeping staff had extractors however they were not able to see where the urine was deposited. The urine seeped into the carpet and dried out over time, leaving lingering odours. [s. 87. (2) (d)]

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 procedures are developed and implemented for the cleaning of the home and equipment, supplies and devices and to address lingering odours, to be implemented voluntarily.

WN #23: 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. Hazardous substances were identified to be accessible to residents in the following areas:

A) On May 3 and 7, 2013, in a room the following items were accessible: varathane (labelled as toxic), primer (labelled as toxic), iodine and rubbing alcohol.
B) On May 3 and 7, 2013, in a room two bottles of iodine were accessible.
C) On May 1 and 2, 2013, in a room three bottles of iodine and bottle of toilet bowl cleaner were accessible.
D) An unattended housekeeping cart, contained an accessible spray bottle of carpet cleaner and floor polisher, neither bottle was labelled properly.
E) On May 1, 2013, spray bottles of disinfectant were accessible in unlocked cabinets or unlocked shower rooms on three home areas.
F) On May 1, 2013, at 1420 hours, kitchen and serveries for two home areas were accessible to residents. Both servery swing doors and the doors to the kitchen were left ajar. The kitchen had sanitizing products on shelves. No staff were present in the serveries, dining rooms or kitchen at the time of observation.
G) On April 22 and 23, 2013, a tub room door was closed but not secure. The room contained a bottle of disinfectant. [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 labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #24: 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. Not all drugs were stored in an area or a medication cart that was secure and locked.

The medication cart was observed on May 23, 2013, at 1012 hours to be unlocked and unattended for over ten minutes. The nursing staff confirmed that they had left the medication cart unlocked and unattended earlier when utilizing the cart. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or cart that is secured and locked, to be implemented voluntarily.

WN #25: 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).