Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2017	2017_536537_0015	005564-17	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

NANCY SINCLAIR (537), DEBRA CHURCHER (670), HELENE DESABRAIS (615)

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): March 20, 21, 22, 23, 24, 28, 29, 30 and 31, 2017

The following intakes were completed within the RQI:
Log #016532-16/CIS 3047-000038-16 critical incident related to allegation of abuse of a resident
Log #016572-16/CIS 3047-000037-16 critical incident related to allegation of neglect of a resident care needs

Log #017855-16/CIS 3047-000049-16 critical incident related to allegation of abuse of a resident
Log #019923-16/CIS 3047-000054-16 critical incident related to improper care post fall
Log #020154-16/CIS 3047-000055-16 critical incident related to a fall resulting in injury
Log #020498-16/CIS 3047-000059-16 critical incident related to allegation of abuse of a resident
Log #020529-16/CIS 3047-000057-16 critical incident related to allegation of resident to resident abuse
Log #024014-16/IL-46119-LO complaint of allegation of abuse of a resident
Log #032076-16/CIS 3047-000087-16 critical incident of allegation of abuse of a resident
Log #032116-16/IL-47850-LO complaint of allegation of abuse of a resident
Log #032121-16/IL-47851-LO/IL-47849-LO complaint of not receiving meals
Log #032642-16/CIS 3047-000089-16 critical incident related to allegation of abuse of a resident
Log #033435-16/CIS 3047-000095-16 critical incident related to allegation of abuse of a resident
Log #034415-16/CIS 3047-000098-16 critical incident related to a fall resulting in injury
Log #034446-16/CIS 3047-000099-16 critical incident related to allegation of abuse of a resident
Log #002353-17/IL-49084-LO complaint related to allegation of improper care of a resident and insufficient staffing

The following intakes were inspected at the same time as the RQI and can be found in a separate report(s):
Log #002803-17/IL-49187-LO complaint related to insufficient staffing and plan of care not being followed
Log #025699-16/CIS 3047-000070-16 critical incident related to allegation of abuse of a resident
Lot #033008-16/CIS 3047-000092-16 critical incident related to allegation of abuse of a resident
Log #031753-16 complaint related to allegation of abuse of a resident and staff qualifications and training
Log #013826-16/CIS 3047-000016-16 critical incident related to allegation of abuse of a resident

Log #032323-16/CIS 3047-000088-16 critical incident related to allegation of abuse of a resident
Log #000017-17/IL-48653-LO complaint related to allegation of abuse, improper care of a resident

During the course of the inspection, the inspector(s) spoke with the President and Chief Operating Officer, Administrator, Director of Care, Assistant Director of Care, Business Director, Resident Care Coordinator, Resident Assessment Instrument (RAI) Coordinator, Recreation Services Manager, Dietary Services Manager, two Registered Practical Nurses, five Registered Practical Nurses, 14 Personal Support Workers, one Housekeeping Aide, Resident's Council President, Family Council President, residents and families.

During the course of the inspection, the inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, policies and procedures, training records, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **8 WN(s)**
- **7 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

Residents were observed walking behind the nurses' stations on all floors on March 20, 21 and 22, 2017, during stage 1 of the RQI.

On March 22, 2017, at 0830 hours, Inspectors observed an unlocked and open drawer at fourth floor's nursing station, containing three pairs of scissors and one screwdriver. The Inspector gave the scissors and screwdriver to a Registered Practical Nurse (RPN) to be secured.

During an interview, a Personal Support Worker (PSW) and an RPN, both stated that the drawer was never locked and that the scissors and screwdriver should be kept in the medication room or the medication cart and not accessible to residents.

On March 22, 2017, at 0850 hours, Inspectors observed an unlocked drawer at third floor's nursing station containing two pairs of scissors.

During an interview, Registered Practical Nurse /Resident Assessment Instrument Coordinator (RPN/RAI) stated that the scissors should be locked in the medication room and acknowledged that the drawers at the nursing stations on all units were accessible to residents.

On March 22, 2017, at 0925 hours, Inspectors observed an unlocked drawer at first floor's nursing station, containing one lighter, two nail clippers, one screwdriver and a metal nail file.

During an interview, Resident Care Coordinator stated that the home's expectation was that such items should not be kept in the drawers where residents had access. The items were then removed from the drawer.

The severity was determined to be a level 2 minimal harm or potential for actual harm. The scope of this issue was pattern, being noted on three of four units. There was a compliance history of this legislation being issued during a complaint inspection on July 29, 2015 as a Voluntary Plan of Correction (VPC). [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice.

A complaint was received at the Ministry of Health and Long Term Care infoline that a resident had not received bathing twice a week as scheduled, and the home being understaffed.

The home's policy titled, "Resident Bathing Program - NAM-K-10" dated January 2014 stated: "It is the policy of Sharon Village Care Homes that each Resident will be accommodated baths and/or showers at a minimum of once or twice a week as per their direction".

The care plan for the resident had a focus and specific interventions with direction for bathing twice a week, and if an alternative method of bathing was provided, to notify Registered Staff.

A review of the home's "Point of Care Audit report" did not include documented evidence that the resident had received bathing as outlined on several days, and that an alternative method of bathing was not provided, and Registered Staff had not been notified.

A Registered Nurse stated that the expectation of the home was that residents received bathing twice a week as per the plan.

The RAI Coordinator agreed that documentation of the provision of bathing was not completed, and that if there was no documentation the care was considered not to have taken place.

The Administrator stated that the home's expectation was that residents would receive two baths twice per week.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated. There was a compliance history of this legislation being issued as a Voluntary Plan of Compliance (VPC) during the Resident Quality Inspection on January 20, 2016. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

During staff interview of Stage 1 of the Resident Quality Inspection, the Resident Assessment Instrument (RAI) Coordinator stated that a resident had areas of altered skin integrity. Chart review during stage 1 also found that a resident had a wound assessment completed for the areas of altered skin integrity.

Registered Practical Nurses (RPN) stated during interview that when a resident is assessed as having an area of altered skin integrity, assessments are to be completed using the home's document, "Wound Assessment - Initial and Ongoing 2014 (SVCH)" located in Point Click Care under the Assessments tab. Both RPNs stated that this form was used for an initial assessment, ongoing assessments and final assessments once a wound was considered healed. Both also stated that it was expected that any area of altered skin integrity was to be assessed and documented on the "Wound Assessment - Initial and Ongoing 2014 (SVCH)" form by a registered staff weekly at minimum. Further interview with an RPN was conducted regarding this resident and the RPN stated that a weekly wound assessment should have been completed on each area identified for this resident . The RPN stated that a weekly assessment had not been completed on one area of altered skin integrity for this resident at all, and if not completed on the second area of altered skin integrity, that it should have been completed.

The home's policy titled "Skin and Wound Care Program Implementation, CPM-F-20" last revised Feb 2016 stated: "Wound Assessment Initial/Ongoing - will be completed by a Registered Staff at a minimum of once weekly. The Initial and Ongoing Wound Assessment is implemented when a resident has any open area involving the dermal layer and deeper (including surgical wounds), Skin Tears will be assessed using the Skin Tear(s) Assessment. One assessment is completed per wound. The treatment regimen is also recorded on the Treatment Administration Record (TAR)"

Record review was completed for this resident and noted the following regarding the completion of the "Wound Assessment - Initial and Ongoing" assessments:

One area of altered skin integrity had an assessment completed as an initial assessment and then no other assessments were completed until the area was noted to be healed, 43 days later. A Registered Practical Nurse stated during interview that weekly assessments had not been completed on the wound.

Another area of altered skin integrity had assessments completed weekly on eight of eleven times as required, 72 per cent of the time. The Director of Care reviewed the clinical record for this resident and also stated that the assessment as noted were missing.

The Director of Care stated during interview that all areas of altered skin integrity, including the identified areas for this resident should have had an assessment completed

at minimum weekly by a registered nursing staff.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated. There was a compliance history of this legislation being issued in similar area as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection on January 20, 2016. [s. 50. (2) (b) (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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: 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 licensee has failed to ensure that there was a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

During census record reviews in Stage 1 of the Resident Quality Inspection, March 20, 21 and 22, 2017, weights were missing for six of forty residents, 15 per cent of the residents who were reviewed.

During census record review of Stage 1 of the Resident Quality Inspection, March 20, 21 and 22, 2017, heights were missing for eight of forty residents, 20 per cent of the residents who were reviewed.

The home's policy titled "Weights - NAM-F-60" dated January 2014, stated : "All residents will be weighed on admission and monthly thereafter. Weights will be documented on the Electronic Health Record (EHR) via Point of Care (POC) documentation. The assigned PSW/HCA will weigh each resident on the first bath day of the month and will document the weight on the weight task in POC".

The home's policy titled "Determining Goal Weight Ranges - DTW-A-70", dated February 2012, stated: "The RD calculates current BMI, based on an accurate admission weight and admission height, as determined using accepted procedures. The Registered Dietitian reassesses the goal body weight range on a regular basis (Minimum yearly, at the time of the annual assessment)".

The Registered Practical Nurse/Resident Care Coordinator (RPN/RAI) acknowledged that residents were missing weights. The Registered Practical Nurse-Resident Care Coordinator shared that the RPN/RAI Coordinator had a process for taking monthly residents' weights and also acknowledged that residents were missing heights.

The RPN/RAI Coordinator stated that the home's expectation was that residents weights should be taken on admission and monthly and, heights taken on admission and yearly.

The RPN/RAI Coordinator shared that resident's weight should be taken on admission and monthly and heights taken on admission and yearly. The RPN/RAI Coordinator shared that the home has implemented a process for taking heights annually within the past few months.

The Administrator and DOC agreed that resident's weights should be taken on admission and monthly and, heights taken on admission and yearly and that the home previously had no policy or process on heights being taken on admission and annually thereafter.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated. There was a compliance history of this legislation being issued as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection on January 20, 2016. [s. 68. (2) (e) (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 there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (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.

A Critical Incident System (CIS) stated that the family of an identified resident had raised concerns to the Administrator that the resident had altered skin integrity and felt it might be related to lack of the provision of care.

Clinical record review for the resident included orders from a physician for the administration of medication as an intervention to address a specific condition being experienced by the resident.

Record review of the electronic Medication Administration Record (eMAR) did not indicate that the resident had received the medication when the resident had experienced the condition for which the medication was ordered. The home's internal investigation notes concluded that the medication had not been administered as per the directions for use specified by the prescriber. The Administrator stated that it would be expected that medications would have been administered as specified by the prescriber.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was isolated. There was a compliance history of this legislation being issued in similar area as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection on January 20, 2016. [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 #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, with a record of immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Care (DOC), the prescriber of the drug and the attending physician or registered nurse in the extended class.

An Inspector and the Director Of Care (DOC) reviewed all medication incident reports from December 2016, January 2017 and February 2017 as well as the related documentation. There was a total of ten incident reports reviewed.

The home's policy titled "Medication Incident Report - 9-1" last reviewed April 2016, stated “When a medication incident occurs, record it on the Medication Incident Report form and communicate it to proper authorities (e.g. head Nurse/DOC/ADOC/Physician/Pharmacy)".

Documentation of post medication incident assessments or actions taken to assess and maintain resident’s health were not able to be located for four of ten medication incident reports, 40 per cent of the time.

Documentation of post medication incident notification of the Power of Attorney (POA) was not able to be located for four of ten medication incident reports, 40 per cent of the time.

Documentation of post medication incident notification of the Physician was not able to be located for four of ten medication incident reports, 40 per cent of the time.

Documentation of post medication incident notification of the Pharmacy was not able to be located for four of ten medication incident reports, 40 per cent of the time.

The DOC acknowledged there was no follow-up assessment completed for four medication incidents reviewed. The DOC acknowledged that there was no POA notification for four medication incidents reviewed. The DOC acknowledged that there was no Physician notification for four medication incidents reviewed. The DOC acknowledged that there was no pharmacy notification for four medication incidents reviewed. The DOC acknowledged it was the expectation of the home that any medication incidents would be documented, including follow-up assessments, the notification of the POA or resident, Physician and Pharmacy. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed and corrective action was taken as necessary.

The home’s policy titled "Medication Incident Report - 9-1" last reviewed April 2016 stated, “Action taken to Prevent Reoccurrence contains details of steps taken to prevent the same error from reoccurring. This area on the form may be completed by the

pharmacy or the DOC at the facility".

Documentation was not able to be located to support that a review and analysis for five of ten medication incidents, 50 per cent, had been completed.

Documentation was not able to be located to support that follow-up actions or corrective actions to prevent reocurrence that would include the actions taken and with whom, for five of ten medication incidents, 50 percent, had been completed .

The Director of Care (DOC) acknowledged that there was no supporting documentation regarding follow-up actions or corrective actions to prevent reocurrence that would include the actions taken and with whom, for five of ten medication incidents. The DOC acknowledged that there was no documented review or analysis of the medication incidents that were reviewed. The DOC shared that it was the expectation of the home that each medication incident was reviewed and analysed and corrective actions were implemented. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse reactions that had occurred in the home since the time of the last review and a written record was kept.

Documentation was not able to be located to support that the home was completing quarterly reviews of all medication incidents and adverse drug reactions that had occurred in the home since the last review in order to reduce and prevent medication incidents and adverse reactions.

The Director of Care (DOC) stated that quarterly reviews of their medication incidents were not being completed. The DOC stated that the pharmacist reviewed the medication incident reports periodically and the last time this was done was November 13, 2016. The DOC stated that it was the expectation of the home that there was a quarterly review and analysis of all medication incidents in the home.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was widespread. There was a compliance history of this legislation being issued as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection on January 20, 2016. The home was aware of the issue before being brought to the licensee's attention and a plan of correction had already been implemented. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is documented, with a record of immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Care (DOC), the prescriber of the drug and the attending physician or registered nurse in the extended class;
to ensure that all medication incidents and adverse drug reactions are reviewed and analyzed and corrective action is taken as necessary;
to ensure that a quarterly review is undertaken of all medication incidents and adverse reactions that have occurred in the home since the time of the last review and a written record is kept, to be implemented voluntarily.

WN #7: 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.

Inspectors observed the following:

March 22, 2017, 0830 hours, in the fourth floor shower room:

One nail clipper with debris located on the window shelf

In the tub room's storage cabinet the following were observed:
Three unlabelled and used sticks of deodorant

Two unlabelled black combs with hair
One green and one blue razor with hair
One white and pink comb with debris
One rusted nail clipper
Two unlabelled, used razors
One unlabelled pink and black brush on the window shelf
One sharps container full of razors sticking out of the container
One drawer containing an unlabelled silver brush with hair and three nail clippers with debris

A Personal Support Worker (PSW) stated that the homes expectation was that all personal items should be labelled and nails clippers and razors should be stored in the resident drawers in the tub room.

March 22, 2017, 0850 hours, in the third floor shower room:

One blue razor with debris and hair
One silver and one blue brush with hair

In the tub room's storage cabinet the following were observed:
Three unlabelled nail clippers with debris
Two unlabelled and used sticks of deodorant
One unlabelled silver hair brush with hair
One sharps container full of razors which were sticking out of the container

In the supply drawer of the cabinet there were two nails clippers with debris, nails and hair in the same container as new combs and new nails clippers.

The Registered Practical Nurse/ RAI-Coordinator (RPN/RAI) stated that the home's expectation was that personal items should be labelled. All nail clippers and razors should be kept in the resident drawers in a box in the tub room. Brushes, combs, deodorant should all be labelled and kept in the resident's rooms when they are not having a bath. The RPN/RAI stated that all of the items out of the drawer that had both new items and soiled items would now need to be discarded as the clean items were now contaminated.

March 22, 2017, 0910 hours, in the second floor shower room:

One unlabelled used razor with hair

In the tub room's storage cabinet the following were observed:
One unlabelled and used toothpaste tube
Eleven unlabelled and used sticks of deodorant and one used roll on deodorant
Four unlabelled black combs with hair
One unlabelled rusted nail clipper
One used bar of soap in an unlabelled box
One sharps container full of razors which were sticking out of the container

In the supply drawer of the cabinet, there were six unlabelled black combs with debris and hair with other new and unused combs and nail clippers.

In the residents' supply drawers, one unlabelled drawer contained one unlabelled black comb with debris, one unlabelled used nail file and one rusted nail clipper.

A Registered Practical Nurse stated that the home's expectation was that all personal items should be labelled to determine who the items belonged to. The RPN stated that razors and nail clippers should be labelled and kept in the labelled boxes in the tub room and that hair brushes, combs, deodorant and soap should be labelled and kept in the residents' room unless being used at the time in the tub room.

March 22, 2017, 0925 hours, in first floor shower room:

One razor with hair and two used bars of soap, located on the sink

In the tub room's storage cabinet the following were observed:
One used bar of soap in an unlabelled box
One unlabelled used toothpaste tube
One silver and one pink brush with hair, unlabelled
In the supply drawer of the cabinet there was one unlabelled black comb with hair, four unlabelled nail clippers with debris amongst new combs and new nail clippers
One unlabelled nail clipper with debris, found on the top of the sink

The home's policy titled "Resident Personal Care Supplies - C-D-60" revised March 2016, stated: "The Resident's personal care supplies will be appropriately used, labelled, cleaned and disinfected to prevent transmission of micro-organisms. Control Measures. Use separate care items for each resident; DO NOT share personal care supplies (e.g.

soap, shaving razors etc); All Resident care supplies must be individually labelled; Discard or appropriately disinfect any Resident care items that touches the floor; Avoid contact or contamination of personal supplies with contaminated areas".

During an interview, the RPN/RAI Coordinator stated that the home's expectation was that all residents' personal care supplies should be labelled to prevent contamination. The RPN/RAI Coordinator stated that the sharps containers on all floors were to be taken by the PSWs to the RPNs for disposal.

The severity was determined to be minimal harm or potential for actual harm. The scope of this issue was widespread. There was a compliance history of this legislation being issued in similar area as a Compliance Order (CO) during the Resident Quality Inspection on January 20, 2016 and was complied on June 22, 2016. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The care plan for a resident included specific interventions for the provision of personal hygiene.

A Personal Support Workers (PSW) stated that the care provided to the resident was not the same as outlined in the care plan, and if the care plan interventions were followed, the task would not be completed. Both stated that the care plan was not reflective of the care the resident required for their personal hygiene needs.

Clinical record review of the Point of Care (POC) task of personal hygiene supported that the care as outlined by PSWs during interview was consistent, and was not what was in the plan of care.

A Registered Practical Nurse stated that the care plan had not been updated to reflect the actual needs of the resident related to personal hygiene.

The Director of Care stated that it was the expectation that the plan of care was based on the resident's needs.

The severity was determined to be minimum risk. The scope of this issue was isolated. There was a compliance history of this legislation being issued as a Compliance Order (CO) during the Resident Quality Inspection on January 20, 2016 and reissued as a Director Referral on June 13, 2016 during a Follow Up inspection. This was complied on July 20, 2016. [s. 6. (2)]

Issued on this 13th day of April, 2017

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

Original report signed by the inspector.