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

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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
Jul 14, Aug 26, 2015	2015_291552_0018	O-002286-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

THORNTONVIEW
186 THORNTON ROAD SOUTH OSHAWA ON L1J 5Y2

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

MARIA FRANCIS-ALLEN (552), CHANTAL LAFRENIERE (194), KARYN WOOD (601), KELLY BURNS (554)

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): June 15-19, 22,23,26, 29 & 30, 2015

Also inspected during the Resident Quality Inspection:
Follow-up Inspection log # O-001603-15, one Complaint log # O-002020-15 and five Critical Incident logs # O-001512-15, #O-001914-14, # O-002132-13, # O-002343-15 and # O-002175-15

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), RAI Co-ordinator, Personal Support Workers (PSW), Physician, Staff Educator, Physiotherapist (PT), Program Manager, Activity Aide, Food Services Manager, Dietary Aide, Environmental Services Supervisor (ESS), Housekeeper, President of Family and Resident Council, family and residents.

Also toured the home, observed dining service. medication administration, infection control practices, staff to resident interaction during provision of care. Reviewed clinical health records, staff education records, relevant policies - Dementia Care, Infection Prevention and Control,Prevention of Abuse, Falls, Safety in Ambulating Lifting and Transferring, Minimizing of Restraints and Medication Administration.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2014_293554_0039	552
O.Reg 79/10 s. 36.	CO #001	2014_293554_0039	552

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. 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 failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed on identified dates 2015:

- Walls – observed to have chipped paint, wall paint 'bubbling/buckling' and wall damage (holes, dry wall and or steel beading exposed on wall corner edges and by closet), in several resident room(s) and washrooms located on Pine Grove and Rose Garden ; in Spa and Shower Rooms located on Pine, Rose Garden, Corbett and Trillium Court; and throughout the hallways on Corbett and Trillium Court.

- Door Frames and Doors – were observed in resident rooms to have paint chipped and gouged areas, located on Pine Grove.
- Wall Guard – observed in resident rooms to be chipped, loose or missing, located on Pine Grove.

- Chairs- home owned chairs in resident rooms were observed to have shellac coating worn and or discolored on chair legs; located on Pine Grove.

- Vent – observed to have dark gray/black build up in a resident washroom located on Pine Grove and in the Spa/Shower room on Pine Grove Resident Home Area.

- Toilet(s) – dark brown/black staining was visible around base of toilet and flooring in a resident's washroom located on Pine Grove ; and in communal washrooms located on Pine Grove, Rose Garden and around the toilet located in Pine Grove Spa Room.

- Hand Rails – observed to have paint chipping on the Pine Grove Resident Home Area hallways.

- Floor Tiles – laminate flooring tiles in residents rooms were observed chipped and or cracked; located on Pine Grove (as well as a hole in flooring behind door); brown staining between floor tiles located in the washroom in a resident's room .

- Carpets – staining observed on carpeting located throughout Pine Grove (RHA), in the lounge/chapel area, in the foyer leading toward Corbett (RHA) and in areas thorough

Trillium Court (RHA).

- Trillium Court Shower Room – strong unpleasant odor upon entrance. The wall by the shower stall is soft and has visible black staining.

- Flooring – laminate flooring brown stained that appears worn in residents rooms located on Pine Grove , and in Spa Room located on Corbett Resident Home Area.

- Flooring – observed to be split, cracked and or lifting in areas throughout the Spa/Shower rooms located on Pine Grove (additional holes in flooring), Rose Garden, Corbett and Trillium Court. Areas of exposed sub-flooring were visible and contained dust and or debris build-up and some areas were noted to be moist from water. (Note: uneven flooring poses a potential trip and fall hazard; moisture poses a potential infection control issue).

- Spa Room - walls tiles were observed chipped and or cracked on the walls and shower stall in Pine Grove and Rose Garden Resident Home Areas.

- Shower Stall – build-up of brown staining on shower stall walls, shower flooring and flooring threshold located on Pine Grove Resident Home Area.

- Bed Rail – ½ bed rail was observed loose on a home owned bed in a resident's room on identified dates.

- Mattress Stoppers – observed to be missing on three resident's beds located on Pine Grove; the mattress on these beds were observed to easily slide causing a gap between top of mattress and head board of approximately 3.5- 4.0 inches. Bolster was applied to the identified beds.

The Maintenance Repair Requisitions Reporting binders are located on each unit. The binder located on the Pine Grove Resident Home Area (RHA), was reviewed for a three month period, work requisitions in this binder failed to identify any of the above noted maintenance deficiencies for the Pine Grove RHA.

Executive Director (ED) indicated the following:
- quotes have been obtained and approved by Revera Corporate Office for the repair of flooring in Spa Rooms located in Pine Grove and Rose Garden; no official date was provided for the anticipated repairs.

- wall repairs for Trillium Court (RHA) shower room had been approved in the capital expenditures; no official date was provided for the anticipated repairs and or replacement.
- was unsure if Environmental Services Manager (ESM) was aware of wall damage and other deficiencies identified for areas on the Pine Resident Home area, but would discuss with ESM and have completed as soon as possible.

The ED indicated it is an expectation that preventative maintenance within the home is identified and that repairs are completed to ensure the home is kept in a safe condition and maintained. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident 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. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007,c. 8, s. 31. (1), by ensuring the restraining of the resident is included in the resident's plan of care; s. 31. (2) 4 a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraint; s. 31. (2) 5. consent received by the resident or a substitute decision-maker if the resident is incapable and s. 31. (2) 6. the plan of care provides for everything required under subsection 3 including the resident being monitored while restrained.

Resident #29 has a diagnosis that includes both cognitive and physical impairment. Resident was observed on three consecutive days in bed (at approximately 12:30 through to 14:30 hours) with two ¾ bed rails engaged.

PSW #116, #117, and RPN #120 indicated that two bed rails are utilized whenever

Resident #29 is in bed. PSW #116 and #117 both indicated the bed rails are intended for safety purposes, so that resident does not fall from bed.

RPN # 120 indicated Resident #29 is unable to reposition and or transfer self on own, and indicated bed rails may be for safety purposes, although Resident #29 has had no recent history of falls.

A review of the plan of care failed to provide evidence that two ¾ bed rails are being utilized for Resident #29.

The Assistant Director Of Care (ADOC) indicated the written plan of care should include the two ¾ bed rails, the goals the care is intended to achieve and most importantly clear direction to staff. ADOC acknowledged that the use of two ¾ bed rails for Resident #29 was not indicated in the written plan of care at the time the bed rails were observed in use.

Physician's orders were reviewed, for a six month period, and failed to identify two ¾ bed rails were ordered by the Physician for Resident #29. During an interview, the physician for Resident #29 indicated he had not ordered the use of two ¾ bed rails and did not believe such were required for this resident.

ADOC indicated the use of two ¾ bed rails would be considered a restraint and as such use required a physician's order.

A review of the clinical health record (both electronic record and paper chart, including progress notes, consents, written care plan and care conference notes), for a three month period, for Resident #29 failed to provide evidence that the family of this resident consented to the use of two ¾ bed rails.

RPN #120 indicated Resident #29 was not able to give consent as the resident has a diagnosis of severe cognitive impairment.

RPN #120 and ADOC both indicated the use of two ¾ bed rails, would require informed consent, signed by the Substitute Decision Maker (SDM)

RPN # 120 indicated if bed rails (as a restraint) were being monitored hourly, it would be documented by the PSWs in the home's electronic record flow sheets, RPN # 120 was unable to locate monitoring records specific to Resident # 29's bed rails.

The electronic records for the resident were reviewed for a one month period and failed to provide evidence that bed rails, as a restraint, were being monitored and documented hourly by the PSWs. RAI Coordinator was unable to provide monitoring records for this same time period.

ADOC indicated two ¾ bed rails for Resident # 29 would be considered a restraint and the expectation would be that restraints are monitored hourly by PSWs; ADOC indicated there should be corresponding monitoring records indicating hourly safety checks by PSWs. [s. 31. (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 staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, included in the plan of care and that the resident is being monitored at least every 2 hours and that consent has been documented, to be implemented voluntarily.

WN #3: 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 failed to comply with LTCHA, 2007, s. 33 (4) 3, by ensuring the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if the use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

Resident #11 has a diagnosis that includes cognitive and physical impairment. The resident is dependent on staff for mobility and positioning. According to the physician and a Registered Practical Nurse (RPN) resident is unable to give consent; both indicated tilt wheelchair is utilized for positioning purposes.

Resident #11 was observed in a tilt wheelchair, with the tilt engaged on three consecutive days.

The plan of care indicated Resident #11 uses a tilt wheelchair for positioning purposes; there is no evidence within the clinical health record that the use of a tilt wheelchair was approved by either a nurse, a physician, a physiotherapist or an occupational therapist.

Resident #28 is cognitively well and was observed in bed with two ½ bed rails engaged on two consecutive days.

PSW #116, 117 and RPN #120 indicated the bed rails are used by Resident #28 for turning and or repositioning. All staff indicated the resident is unable to release bed rails herself due to physical limitations and use of bed rails were the choice of Resident #28.

There is no indication in the plan of care that the use of two ½ bed rails as a PASD has been approved by a physician or registered nursing staff.

The ADOC indicated that to date no assessment for Resident #28's bed rails has been completed by the registered nursing staff. She also indicated that all bed rails, used as a PASD, are in the process of being assessed by herself as this was an identified deficiency from the last Resident Quality Inspection.

The ADOC indicated the expectation according to the home's policy, PASD (#LCT-J-30) is that all bed rails, used as a PASD are to be assessed by a nurse or a physician. [s. 33. (4) 3.]

2. The licensee failed to comply with LTCHA, 2007, s. 33 (4) 4, by ensuring the use of a Personal Assistance Services Device (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: 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.

Resident #11 has a diagnosis that includes, cognitive impairment. Resident was observed in a tilt wheelchair with tilt mechanism engaged on three consecutive days. The written plan of care indicated Resident #11 utilizes a tilt wheelchair as a PASD for

positioning purposes.

The Physician and RPN indicated the resident is unable to release self from the wheelchair if the tilt mechanism is engaged; both indicated resident no longer is able to walk unassisted and uses the tilt wheelchair for positioning and comfort purposes.

The clinical health record was reviewed, for a six month period and failed to provide consent by the resident's SDM for the use of a tilt wheelchair as a PASD.

RPN #120 and the ADOC both indicated the use of a PASD requires consent by the resident's SDM if the resident is unable to provide consent.

Regarding Resident # 19

Resident #19 diagnosis includes, cognitive impairment. RPN #120 indicated Resident #19 is unable to give consent.

The plan of care and physician's orders both indicate Resident #19 uses a tilt wheelchair as a PASD for positioning purposes.

Resident #19 was observed in the tilt wheelchair with the tilt engaged on three consecutive days. PSW #116, 117 and RPN #120 indicated the tilt wheelchair for Resident #19 was used daily for positioning and to prevent the resident from falling.

RPN #120 reviewed the home's policy (Personal Assistive Service Devices, # LTC-J-30) and indicated that it is the home's policy that all PASDs require consent by the resident or Substitute Decision Maker (SDM), for residents with cognitive impairment.

There was no evidence of the family of Resident #19 consenting to the use of a tilt wheelchair as a PASD.

ADOC and DOC indicated the expectation is that PASDs require consent by the resident's SDM.

Related to Resident # 28

Resident #28 is cognitively well and was observed in bed and using two ½ bed rails on two consecutive days The written plan of care indicated Resident #28 is cued to reach

for bed rails for bed mobility purposes and uses a tilt wheelchair as a PASD for positioning purposes.

PSW #116, 117 and RPN #120 all indicated two ½ bed rails and a tilt wheelchair are used by Resident #28 for positioning purposes; all staff indicated resident is unable to release bed rails and tilt wheelchair when engaged due to physical limitations.

A review of the clinical health record for a three week period failed to provide evidence of consent for use of bed rails and tilt wheelchair by Resident #28 or the SDM.

RPN #120 and ADOC indicated that all PASDs require consent either by the resident (if cognitively well) and or th SDM.

Related to Resident #29

Resident #29 has a diagnosis of cognitive impairment. Resident is dependent on staff for all activities of daily living. Resident #29 was observed in the tilt wheelchair with the tilt engaged, anywhere from 30 to 90 degree's during an identified period.

The plan of care indicates the following:
- requires total support for all ADLs as evidenced by inability to participate in tasks due to, cognitive and physical limitations. Interventions include, uses tilt wheelchair
- requires the use of a PASD (Tilt Wheelchair) to assist with positioning and comfort due to, skin integrity risk, need for comfort and positioning, poor positioning, poor posture and cognitive impairment Goals: Will remain free of complications related to PASD use through to next review. Interventions include, PASD is applied as per manufacturer's instructions; check q2 hours and repositioned; if exhibiting any signs of discomfort, physical or emotional inform the Nurse immediately.

The Physician's Medication Review, for an identified date was reviewed and does provide an order for the use of a tilt wheelchair to be used as a PASD for positioning purposes.

Interviews with PSW (#116 and #117), RPN # 120, and the physician indicated Resident #29 is unable to release self from the tilt wheelchair due to cognitive and or physical limitations. All staff members interviewed indicated the tilt wheelchair is considered a PASD for this resident.

A clinical health record review failed to provide supporting evidence that the SDM has provided consent for the use of the tilt wheelchair as a PASD.

Both the DOC and ADOC indicated the expectation would be that residents using PASDs would have SDM consent on file. [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 the use of PASD for all residents have been approved by a physician, registered nurse, registered practical nurse, a member of the College of Occupational Therapist of Ontario or member of the College of Physical Therapist of Ontario, to be implemented voluntarily.

WN #4: 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 ensure LTCHA, 2007 s. 57(2) that the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Resident Councils' meeting minutes for the month of May 2015 identify a recommendation, "to lower the minutes that are posted in the door so that persons in wheelchairs can see easily and to have extra copies at the front desk for those wishing a copy to peruse."

No written response from the licensee to the May 2015 minutes was provided to the Resident Council.

During interview Recreational/Program Manager (who is the licensee representative on Resident Council) indicated that response from management to Resident Council had not been required over the last few months.

During interview Executive Director indicated the May 2015 minutes should have had a response provided related to location of posted minutes in the home.

Program Manager informed inspector that Resident Council meeting minutes have been posted so that they are accessible to all resident's in the home and a written response will be provided to the Resident Council of the action taken by the home.

Resident Council meeting minutes changed on June 29, 2015. [s. 57. (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 the Resident Council advises the licensee of concerns or recommendation, a written response is received within 10 days, 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 131 (3), by ensuring that no person administers a drug to a resident in the home unless that person is a Physician, Dentist, Registered Nurse or a Registered Practical Nurse.

Resident #66 has a diagnosis that includes cognitive impairment and resides on Trillium Court, the secured resident home area. The resident shares dining room table with two other residents with cognitive impairment.

The following observations were made during the breakfast meal on an identified date:

- RN #122 was observed pouring medication into a thickened beverage and placing the beverage in front of Resident #66's cereal bowl at approximately 08:34 hours. RN #122 did not indicate to the PSW the beverage contained medication nor provide any direction prior to leaving the dining room table and returning to the medication cart.
- PSW #110 was observed spooning the beverage containing the medication into the mouth of Resident #66.
- cup containing ¾ of the beverage containing the medication was left unattended on the table without staff present from 08:45-09:12 hours. Residents #45, 65 and 66 were all within arm's reach of the medication.
- Activity Aide was observed at approximately 09:12 hours spooning the beverage containing the medication into the mouth of Resident #66
- RN #122 left the dining room at approximately 09:30 hours; the beverage containing the medication remained on the dining room table within reach of three residents. The glass contained approximately ¼ of beverage with medications.

PSW #110 indicated being aware that medication was in the beverage, and that registered nursing staff routinely leaves medications in drinks for direct care staff to administer; PSW #110 indicated she had not been provided any direction, from RN #122, specific to administering medication the identified date to Resident #66. PSW #110

indicated having had no education specific to administering medications.

Activity Aide indicated not knowing the beverage she was providing to Resident #66 contained medication and that she saw the resident needed to have fluids and was assisting resident. Activity Aide indicated having no education relating to medication administration.

RN #122 stated "PSWs are considered an extension of the registered nursing staff and are permitted to administer medications in food and or fluids if registered nursing staff are present". RN #122 agreed she had left the dining room from 09:30 to 10:00 hours to attend a meeting.

The DOC indicated registered nursing staff may place medication in beverages and have PSWs provide the beverage (containing medications) to residents if the registered nursing staff is present. DOC indicated the expectation is that registered nursing staff remains present until all medications are consumed by the resident.

In an interview the DOC explained the home does not delegate the task to PSWs of administering medication and the home's policy on medication administration clearly indicates the medication must "be observed for ingestion otherwise it cannot be considered administered". [s. 131. (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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse, to be implemented voluntarily.

WN #6: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, 2.229 (9) by ensuring that there is in place a hand hygiene program in accordance with evidence based practices and, if there are none, in accordance with prevailing practices and with access to point-of-care hand hygiene agents.

The Provincial Infectious Disease Advisory Committee (PIDAC) directs the placement of Alcohol Based Hygiene Rub Dispensers:
Installing alcohol based hand rub dispensers at the point-of-care improves adherence to hand hygiene. Hand hygiene products available at point-of-care are easily accessible to staff by being as close as possible.

There are 154 residents in the home with four units. On Rose Garden unit, 10 out of 11 rooms observed had point-of-care hand hygiene outside of the rooms. Only one room observed on this unit had point-of-care hand hygiene inside of the room. The residents in two rooms were on isolation and contact precaution. Hand hygiene products are not accessible at point of care.

On Pine Grove units, 10 rooms observed had point-of-care hand hygiene outside of the rooms. The resident in one room was on contact precaution. Hand hygiene products are not accessible at point of care.

Three PSW #193, 128 and 139 indicated they did not carry personal hand hygiene with them during provision of resident care. They all indicated that they used the hand hygiene dispense located outside the resident's rooms on the door prior to and after providing care. [s. 229. (9)]

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 there is in place a hand hygiene program in accordance with evidence based practices and if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 34 (2), by ensuring that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care.

Resident #65 has a diagnosis that includes cognitive impairment; resident is dependent on staff for activities of daily living including inserting dentures.
The plan of care for Resident #65 indicates resident has both upper and lower dentures and requires the support of staff. Interventions included in the plan of care are for staff to ensure dentures are in place before each meal.

The following observations were made on an identified date, during the breakfast meal:
- the resident was sleeping at the dining room table with his meal in front of him. A family member of Resident #65 entered the dining room at approximately 08:36 hours and sat beside the resident; family of Resident #65 indicated to staff in the room (RN and two PSW) that resident did not have his dentures.
- RN #122 made no attempt to retrieve the denture(s) or direct care staff to intervene; no staff retrieved denture(s) for Resident #65.
- at approximately 08:54 hours, the family member asked staff for a key to obtain resident's dentures and returned moments later with the resident's upper denture and placed the denture into the resident's mouth.
- Family of Resident #65 indicated resident needed dentures in order to safely eat his meal.

The DOC indicated the expectation is for staff to ensure resident's needing dentures have them inserted, especially prior to mealtimes. [s. 34. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #O-002132-15:

The DOC submitted a Critical Incident Report (CIR) on an identified date, relating to an incident of resident to resident physical abuse which was said to have occurred two days prior.

Details of the CIR are as follows:
- Resident #46 hit Resident #45 on the right shoulder, as the two residents were passing one another in the hallway. Resident #45 reacted to being hit on the shoulder, turned towards Resident #46 and placed his hands over the mouth and neck of Resident #46. Resident #45 pushed Resident #46 against the wall, hitting resident's head on the wall. Both residents were separated by staff. Resident #46 sustained an injury during this altercation.

DOC indicated the police were not notified of the incident, as both residents have a diagnosis that includes cognitive impairment and the police rarely respond to incidents when such are reported to them. She indicated she is aware the police are to be notified of abuse incidents, especially when such involves injury as in this situation and agreed, the police should have been notified of this incident. [s. 98.]

WN #9: 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 failed to comply with O. Reg. 79/10, 2. 129 (1) (b) by ensuring that 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.

During an interview on an identified date with RN #122 indicated a controlled substance is stored in the fridge. The refrigerator is stored in the locked medication rooms.

On an identified date, the locked medication rooms and the unlocked fridges for two units were observed. The fridge on one unit had four vials of the controlled substance , and the other unit's fridge had two vials of the controlled substance.

During an interview with RN #122 and RN #100 it was identified the controlled substance was a stock medication, and is stored in the unlocked fridge with all the other medication that require refrigeration.

During an interview the DOC indicated arrangements will be made to ensure the controlled substance is stored in a separate, double locked stationary fridge. [s. 129. (1) (b)]

Issued on this 26th day of August, 2015

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

Original report signed by the inspector.