Ontario

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

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

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

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


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

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 2, 2013 | 2012_186171_0019 | H-002129-12 | 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**

GARDEN CITY MANOR
168 Scott Street, St. Catharines, ON, L2N-1H2

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

ELISA WILSON (171), BERNADETTE SUSNIK (120), GILLIAN TRACEY (130), MARILYN TONE (167), MICHELLE WARRENER (107)

**Inspection Summary/Résumé de l'inspection**

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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 20,21,22,23,26,27,28,29,30, December 3,4,5, 2012

The following complaint inspections were completed concurrently with this RQI:
H-001831-12
H-001878-12
H-002118-12
H-002149-12
H-002159-12

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Executive Director, Director of Care (DOC), Associate Director of Care, Registered Practical Nurses(RPN), Registered Nurses(RN), Personal Support Workers(PSW), Cooks, Dietary aides, Food Services Manager (FSM), Registered Dietitian, Environmental Manager, Housekeepers, Program Manager, Recreation Aides, Social Worker, Business Manager, Resident Assessment Instrument (RAI) Coordinator, Receptionist/Scheduler, families and residents.

During the course of the inspection, the inspector(s) toured the home,observed meal service and food production, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

**Food Quality**
**Hospitalization and Death**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Quality Improvement**
**Recreation and Social Activities**
**Resident Charges**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**
**Trust Accounts**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |

| | |
|---|---|
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had not ensured every resident had the right to give or refuse consent to any treatment, care or services for which consent is required by law and to be informed of the consequences of giving or refusing consent.

a) Resident #069 returned from hospital with new medication orders, however this information was not provided to the residents' Substitute Decision Maker (SDM) at that time for consent. The SDM became aware of the resident taking a specific drug at a later date and requested the medication be held. There was no documentation found regarding any discussion with the SDM regarding the consequences of refusing the treatment. There was no physicians order to stop the medication at that time. An order was written by the physician to decrease the dosage eleven days later, however, the medication had already been withheld for those eleven days.

The Director of Care (DOC) confirmed the expectation that registered staff reconcile medication orders received from the hospital with previous orders the resident had when in the home. If the reconciliation shows there were differences in medication the new medications and/or dosages must be approved by the physician and discussed with the resident or substitute decision maker for consent. The DOC also confirmed medications should not be withheld for a prolonged period of time by nursing without a physicians order. The DOC confirmed this was not done in this case. (171)

b) The SDM for Resident #001 was not informed and did not give consent for the resident to receive a specific medication. The resident received this medication for a ten day period.

c) Resident #001 was provided specific care despite the direction provided on the signed Advanced Health Care Directive (AHCD) for the resident and wishes expressed by the resident's SDM not to provide this care. It was also noted that when the resident's SDM was called related to the care, the SDM indicated to the registered nursing staff that they did not wish the resident to receive this care. [s. 3. (1) 11. ii.]

2. The licensee had not ensured the resident's right to have a designated person receive information immediately concerning any hospitalization.

Resident #069 was transferred to the hospital. Phone calls were placed by staff of the home to one family member, however this person was not available. No further attempt was made to contact other family members listed for the resident. This

situation was confirmed by the DOC. The DOC confirmed the expectation other family members be contacted when the primary contact is not available. [s. 3. (1) 16.]

3. The licensee had not ensured that all residents have the right to have their lifestyle and choices respected.

Morning care for at least ten residents was completed before 0555h. The care for four of these residents was already completed by 0535h. The noted residents were on a list for the night shift to complete morning care, including getting dressed. There was no documentation in the plans of care to confirm these residents or the resident's SDMs had their choice regarding time to wake up assessed.

Night staff confirmed they are each expected to complete morning care on five residents before the end of their shift at 0700h. Registered staff confirmed some residents get up early on their own, however not all of the residents on the night shift list would be awake at that time. One resident was dressed and returned to bed and some were sitting up but sleeping in their chairs. One resident was in the dining room calling for breakfast at 0555h at which time the resident was provided with an ice cream, however breakfast was not served until after 0800h. [s. 3. (1) 19.]

***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 resident's rights are fully respected and promoted, to be implemented voluntarily.***

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee had not ensured the plan of care for each resident set out clear directions for the staff and others who provided direct care to the resident.

a) The plan of care for Resident #004 directed staff to provide a specific textured diet in one section of the plan of care and directed staff to provide a different textured diet in another section of the plan. The plan did not include directions for staff related to special meals required by the resident based on specific treatments being provided. The plan was not clear in relation to diet texture and the provision of special meals. (107)

b) One section of the plan of care for Resident #880 indicated the resident required a specific amount of fluid per day, however, another section of the plan of care identified the resident required a different amount of fluid. The values were inconsistent and did not provide clear direction. (107)

c) The plan of care for Resident #001 was reviewed. The falls section of the document that the home refers to as the care plan found in the care plan binder and confirmed as the most current, indicated the resident had sustained a number of falls:

The care plan that was printed from Point Click Care indicated specific interventions related to falls risk. In another area of the same care plan, the plan indicated a different intervention and different information regarding falls risk.

It was noted in the progress notes that the resident's SDM was called and the writer informed them of certain interventions to prevent falls which did not match the current physician's order regarding a specific intervention.

The plan of care for Resident #001 did not give clear direction to staff related to the resident's safety needs or the use of specific interventions. [s. 6. (1) (c)]

2. The plan of care for Resident #004 was not based on an assessment of the resident and the needs of the resident related to constipation.

The resident was provided PRN (as needed) bowel medications for the treatment of constipation. The resident had also voiced concerns about ongoing constipation, however, constipation was not identified on the resident's plan of care. The resident had multiple risk factors for constipation.

Registered staff confirmed that a plan of care would be required to identify this need and that a plan of care identifying the problem of constipation was not in place. [s. 6. (2)]

3. The licensee had not ensured that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

a) A physiotherapist's assessment completed for Resident #013 indicated the resident needed specific interventions to minimize the risk for falls. However, the nursing assessment indicated the resident required different interventions.

Staff interviews confirmed the resident only used some of the interventions from the assessments.

b) The plan of care for Resident #112 was reviewed. Information on the "head to toe skin assessment tool" was not consistent with assessments completed in the progress notes and on the bath records.

The head to toe skin assessment identified a specific open area on one part of the body, however the other assessments identify an open area on a different part of the body. The assessments were not consistent in the location of the open area. Staff interview confirmed the resident had only one open area.

Information recorded on the bath records for Resident #112 was not consistent with information in the progress notes and skin and wound assessments. The resident was documented as having an open area with healing noted three months later. Bath record documentation related to open areas during the first month of this time period indicated there were no open areas. [s. 6. (4) (a)]

4. The licensee had not ensured that staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

a) Numerous assessments completed by staff identified that Resident #110 was independent for a certain aspect of daily living, however the resident's plan of care identified a safety risk with potential injury if the resident was to perform this task independently.

b) The plan of care for Resident #037, developed by physiotherapy, indicated the resident needed specific interventions for transfers and ambulation, however the plan of care developed by nursing indicated the resident required different interventions for transfers and ambulation.

According to staff interviews, the resident actually required even more assistance than that documented due to the risk of falls. [s. 6. (4) (b)]

5. The licensee had not ensured that the care set out in the plan of care was provided to the resident as specified in the plan.

a) Resident #041 did not have pain assessments completed as per the directions on the plan of care. The resident had significant pain issues. The resident's plan of care had a written physician's order for weekly pain assessments and the care plan directs staff to complete pain assessments weekly.

The Medication Administration Record (MAR) for the resident indicated that the resident was to have pain assessments completed on four specific dates over the course of a month. A review of the Point Click Care progress notes revealed that no pain assessments were completed on three of those dates as required and there were no signatures for these dates on the MAR to indicate that pain assessments were completed.

An interview with the registered staff member confirmed that pain assessments were to be signed for on the MAR and completed in the Point Click Care progress notes. The staff member confirmed that no pain assessments were completed on the specific three dates reviewed.

A second registered staff member interviewed confirmed that the resident should have a Pain Management Flow Sheet included with their MAR because of unresolved pain issues and the need for breakthrough medication. This staff member confirmed that this Flow Record was not being used for the resident.

b) Resident #112 did not have pain assessments completed as per the directions on their plan of care. The resident had a plan of care that required weekly pain assessments and this requirement was also documented on the Medication Administration Record (MAR) as noted over a five month period.

Only three pain assessments were completed during the five months. The resident was taking pain medication and had complaints of pain during this time period.

c) The plan of care for Resident #013 indicated the resident was to have weekly pain assessments completed on four specific dates in a month. Documentation reviewed and staff interviews confirmed that pain assessments were not completed on two of the four weeks.

d) Resident #999 had a plan of care that identified a therapeutic diet was required, however the resident was being fed a food item not consistent with the diet order. The Registered Dietitian confirmed this food item was not to be provided on that specific therapeutic diet. The staff person feeding the resident was unaware that the item was not to be provided to the resident.

e) The plan of care for Resident #001 indicated that staff were to: Assess/record/report to MD prn: signs and symptoms of hypoglycemia and signs or symptoms of hyperglycemia. According to the clinical record the resident was hyperglycemic on at least 12 occasions and hypoglycemic on six occasions within a two week period. According to staff interviewed and documentation reviewed, action was not taken when blood glucose levels indicated the resident was hypo- or hyperglycemic.

f) The plan of care for Resident #013 indicated the resident needed four specific interventions to minimize risk for falls. Resident observations and staff interviewed confirmed the resident did not have any of these four interventions, as specified in the plan. [s. 6. (7)]

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***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 all aspects required for the plan of care according to the Act are complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

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**Findings/Faits saillants :**

1. The licensee had not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy "s 4.2 (3) Administration, Documentation, and Storage; Administering Routine Medications" indicated: Each individual medication is initialed as administered, on the MAR, in the correct boxes, immediately after administration and before the next resident is medicated.

According to the medication administration record (MAR) for Resident #001, there were 29 signature omissions in a three week period for medications and treatments. This information was confirmed by staff interviewed. [s. 8. (1)]

2. Registered staff at the home had not complied with the home's policy and procedure related to Pain Assessment and Symptom Management (LTC-N-60).

The home's policy related to Pain Assessment and Symptom Management directs staff to initiate a Pain Monitoring Flow record if new pain medication is ordered, if there is an increase or decrease in the resident's regular pain medication or if breakthrough pain medication is used for three consecutive days.

a) Resident #041 was noted to have pain. The resident's physician wrote an order to increase pain medication. Four days later the physician adjusted the order regarding pain medication due to the resident's continued and increased pain. One month later the physician indicated in his note that the resident's pain persisted and wrote an order for another increase in the pain medication. A Pain Monitoring Flow Record was not initiated related to these medication changes as directed in the home's policy.

For two months the resident received medication for breakthrough pain numerous times. It was noted that these were administered over three consecutive days each month. A Pain Monitoring Flow Record was not initiated as directed in the home's policy. (167)

b) Resident #013 received 31 PRN (as needed) analgesics in a one month period. Staff confirmed a pain monitoring flow sheet was not initiated as directed in the home's policy. [s. 8. (1)]

3. The licensee had not ensured that the home's Hydration Policy (LTC-H-130-ON)

was complied with by staff.

The policy stated that the Nurse/delegate would review the food and fluid intake record daily and add up the total fluid intake for residents identified at high risk for dehydration and that a referral to the Registered Dietitian would occur if residents consumed less than one litre per day of fluid for three consecutive days.

The following residents were all identified at high nutritional risk.

a) Resident #004 required a specific amount of fluid. Staff confirmed the fluid monitoring records were not totalled daily and that problems with hydration could not be easily identified.

b) Resident #865 did not have intake consistently recorded by staff. Food and fluid intake monitoring records were not totalled daily by staff and 13 meals and snacks were not recorded during the month of November 2012.

c) Resident #998 did not have intake consistently recorded by staff. Food and fluid intake monitoring records were not totalled daily by staff and 18 meals and snacks were not recorded during the month of November 2012.

d) Resident #993 did not have intake consistently recorded by staff. Food and fluid intake monitoring records were not totalled daily by staff and 15 meals and snacks were not recorded in the month of November 2012. A referral to the Registered Dietitian was not initiated when the resident's fluid intake was less than one litre per day for several consecutive days.

Staff interviewed stated they were not aware that the resident had poor fluid intake and confirmed that a dietary referral had not been initiated.

e) Resident #004 did not have intake consistently recorded by staff. Food and fluid intake monitoring records were not totalled daily by staff and 14 meals and snacks were not recorded for the month of November 2012 and 18 meals and snacks were not recorded in the month of October 2012. [s. 8. (1)]

4. The licensee had not ensured that the home's Bowel Protocols for the Prevention of Constipation Policy - LTC-N-15 was complied with.

The policy stated the medical directive was placed in the Doctor's Order section of the chart and pharmacy would be notified of the Medical Directive to ensure it was printed on the monthly medication administration record (MAR). The policy also stated that Registered/Licensed staff would document in the MAR the administration of PRN (as needed) laxatives as per the Medical Order or Medical Directive, and that medication effectiveness would be documented. Registered staff confirmed that PRN medication effectiveness was to be documented on the MAR.

a) Resident #112 had a physician order for specific medications to be given on the third day without a bowel movement and another medication on the fourth day without a bowel movement. The medical order was not complied with by staff providing care to the resident.

Some examples:

Month #1
i) The resident did not have a bowel movement for six days. Interventions were not implemented until day five. The intervention was not documented on the MAR.
ii) The resident did not have a bowel movement for seven days. On day three staff administered medication, however the administration and effectiveness were not documented on the MAR. No further interventions were provided as per the medical order until seven days without a bowel movement when an intervention was offered and refused. This was not documented on the MAR.

Month #2:
i) The resident did not have a bowel movement for eight days, however, staff did not follow the medical orders. An intervention was initiated on day four and then no further interventions were provided until day seven. The interventions were not recorded on the MAR and the effectiveness was not documented.
ii) In another instance staff initiated an intervention on day four, however, this did not follow the medical orders to start on day three and the medications were not recorded on the MAR, nor was the effectiveness documented.
iii) The resident did not have a bowel movement again for a six day period, however, interventions were not initiated until day five. The medication was refused and was not documented on the MAR and no alternative interventions were provided.

Month #3:
i) The resident did not have a bowel movement for a seven day period, however, interventions were not implemented during this period.
ii) The resident did not have a bowel movement for eleven days, however, interventions were not implemented until day eleven when a specific intervention was provided. This medication was not recorded on the MAR and the resident did not have an order for this medication.

The resident had multiple risk factors for constipation.

Registered staff confirmed that interventions were not provided according to the medical directive, that medications and the effectiveness of medications were not documented on the MAR, and that there was no order for one of the medications that was given.

b) Resident #004 had a physician order for a specific medication to be given on day 3 without a bowel movement and a different medication on day 4 without a bowel movement.

Interventions for the treatment of constipation as per the physician's orders were not provided to Resident #004 during a six day period. A medication was provided on the fifth day without a bowel movement. Registered staff confirmed that interventions for the treatment of constipation were not provided. [s. 8. (1)]

5. The licensee had not ensured that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The policy (LTC-N-35 Diabetes management: Treatment of Hypoglycemia) indicated: If blood sugar is below 4mmol/L and the resident does not have specific physician's orders for treatment, immediately provide an appropriate source of 15gm Carbohydrate (Diabetic Food Replacement). If resident is unable to safely ingest food source, administer glucagon. Retest blood sugar in 15 minutes, if blood sugar reading is still below 4 mmol/L, repeat above steps until a level above 4 mmol/L is achieved.

a) According to documentation, Resident #001 had capillary blood glucose(CBG) levels recorded below 4 mmol/L on six occasions in a one week period. Documentation reviewed and staff interviewed confirmed, the resident's CBG levels

were not retested within 15 minutes.

b) According to documentation, Resident #002 had a blood glucose(CBG) level recorded below 4 mmol/L on a specific day at 0800h. Documentation reviewed and staff interviewed confirmed, the resident's CBG level was not retested within 15 minutes as per policy. [s. 8. (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 all plan, policies, protocols, procedures and strategies are complied with, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.**

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**Findings/Faits saillants :**

1. The licensee had not ensured that the lighting levels in the above table had been maintained.

The corridor illumination levels on the 2nd floor were not a continuous and consistent 215.28 lux. Illumination levels were measured using a lux meter. The lux directly under the light was 600 lux and 25-40 lux between the light fixtures. Each light fixture is spaced approximately 10-12 feet apart, with a wall sconce light fixture in between the ceiling light fixtures. The lux levels did not change when the sconce lights were either off or on.

Resident bedrooms did not have an overhead room light and rooms could only be illuminated by the overbed lights. When these lights were all on, the general illumination level in the centre of a random selection of rooms did not meet the required lux of 215.84. [s. 18.]

***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 lighting requirements as set out in this section are maintained, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.**

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**Findings/Faits saillants :**

1. The licensee had not ensured that the home was maintained at a minimum temperature of 22 degrees Celsius.

The air temperatures were noted to be below 22C in the dining rooms for the Burgoyne, Montebello, Short Hills and DeCew home areas which were taken on November 30, 2012 between 1315h and 1345h. Several contributing factors to low air temperatures were noted in each of the dining rooms.

In each of the four dining rooms, two storage rooms are available, all with air temperatures of below 15C. Cold air permeated the dining room from these rooms. Window air conditioners were observed to be located in window openings in each dining room, all without adequate seals or covers. Staff reported that the units remain in the windows all winter. Cold outdoor air (0C) was blowing into the room around the edges of the unit and through the unit at the time of the inspection. In addition, an exhaust fan mounted above the windows in each of these dining rooms (all reported by staff as being non-functioning), were also noted to have cold air blowing through the unit into the room. Only one was covered with a plastic bag which reduced the entry of cold air to some degree. One or both of the electric base board heaters, which are provided under the windows and on an adjacent wall in each of the dining rooms, were cold to the touch in Burgoyne, DeCew and Short Hills. The two wall mounted heaters in the Burgoyne dining room were both off and one was not on in the Montebello dining room.

Several residents occupied tables located directly next to these windows during meals and staff reported that they and the residents were very uncomfortable. Air temperatures were taken in the centre of the room, away from the windows. The temperatures were as follows: Burgoyne: 20C, Montebello: 21C, Short Hills: 18C, DeCew: 21C.

Thermostats located on the walls in each resident room were observed to be set at 60 -70F or 16-21C in many rooms on both the 1st and 2nd floors. Baseboard heaters were cold to the touch on November 29 and 30, 2012. Three residents complained of being cold or uncomfortable in rooms where the heater was cold to the touch. When thermostats were set to 22C, heaters were noted to be functional. Staff were unaware that the thermostats were set below minimum requirement levels and staff were not monitoring the air temperatures. [s. 21.]

***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 is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.***

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee had not ensured the plan of care was based on, at a minimum, an interdisciplinary assessment of sleep patterns and preferences.

The following residents were observed to be up and dressed with morning care completed at the times indicated:

0535h - Resident #926, #700, #069 and #701
0540h - Resident #891 and #702
0555h - Resident #002, #992, #703, and #704

There was no documentation in the residents' plans of care indicating a preference for waking times or whether waking choices were discussed with the resident or SDM. These residents were on the list of residents to have morning care completed by the night shift. Registered staff confirmed resident's sleep patterns and preferences were not assessed or documented in the plan of care. [s. 26. (3) 21.]

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*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 resident's plan of care is based on an interdisciplinary assessment of sleep patterns and preferences, to be implemented voluntarily.*

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee had not ensured that the following was complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the regulation: Not every program included written descriptions of the program that included goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

a) Staff interviewed and management confirmed that the home does not have a policy, procedure or protocol in place related to the management and care of residents who have a Urostomy tube. (130)

b) Staff interviewed and management confirmed the home does not have a policy, procedure or protocol in place for the management of hyperglycemia. [s. 30. (1) 1.]

2. The licensee had not ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

a) The nursing progress notes indicated that Resident #001 had vomited, was afebrile and had high capillary blood glucose readings. The physician wrote an order the same day for a medication and a specific test to determine a diagnosis.

The following day the diagnostics were completed and the home received a faxed report the next day indicating a negative result for the diagnosis in question. It was noted this report was not signed as reviewed by the physician. There was no documentation on the resident's health file to indicate that this report was received or that the physician was notified of the results of this report.

During an interview with a registered staff member, it was confirmed that if any report is received and the report contained information that could result in a change to the resident's plan of care, the physician would be notified. If the report does not contain any information that could precipitate a change in the resident's plan of care, the report would be placed in the physician's book for the physician to review and sign on their next visit.

Resident #001 continued to receive the medication for 10 days as originally ordered.

There is no documentation on the resident's health file to indicate that the resident was reassessed when the diagnostic report was found to be negative, nor was there any documentation to indicate action taken with regards to notifying the physician of the negative report.

b) Resident #100 returned from hospital with a new intervention in place. There was no documented assessment completed regarding this change and the care plan section of the resident's medical record was not reviewed and revised to reflect new goals and interventions required. Subsequently the resident had this device removed, according to an interview with registered staff, however there were no progress notes, assessments or revision to the interventions in the plan of care to reflect the removal of the device.

Registered staff confirmed the expectation that the assessment and plan of care, including interventions, should have been documented when the resident returned from hospital and when the device was later removed. [s. 30. (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 every program includes written descriptions of the program that included goals and objectives and relevant policies, procedures and protocols and that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #8: 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 had not ensured that every resident exhibiting altered skin integrity received 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.

Resident #112, who had altered skin integrity, did not receive a timely skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument.

The skin issue was documented in the progress notes, however an assessment of the area was not completed until 18 days later when it was noted to be infected. Initial documentation did not identify the origin of the skin issue or any details of how it occurred. [s. 50. (2) (b) (i)]

2. The licensee had not ensured that every resident exhibiting altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infections.

Resident #112, who had a large area of altered skin integrity did not receive immediate interventions to promote healing and prevent infection.

The resident had a bandage applied on a specific date. The resident was noted to have an infection in the area identified 18 days later. No treatments or interventions were identified on the Treatment Assessment Record during that time period and treatment was not initiated until infection was identified. [s. 50. (2) (b) (ii)]

3. The licensee had not ensured that every resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff.

Resident #112, who had a large area of altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff.

Registered staff interview confirmed that a weekly skin assessment was required for the skin issue, however, the area was not assessed weekly by registered staff. [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 a clinically appropriate assessment instrument is used for residents with altered skin integrity, that immediate treatment and interventions are received and that resident's are reassessed as least weekly by a member of the registered staff, to be implemented voluntarily.*

**WN #9: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:**
**4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 51 (1).**

**Findings/Faits saillants :**

1. The continence care and bowel management program does not, at a minimum, provide for strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

The strategies used to maximize residents' comfort and dignity including the provision of appropriate equipment for resident's continence care had not been successful to date.

Residents who needed full assistance to be transferred to a toilet were not able to do so in their rooms or ensuite washrooms due to space limitations. Some residents who required assistance were assisted onto a commode chair within the centre of a tub/shower room as an enclosed toilet area was not available. Some of the tub/shower rooms do not have a toilet or hand sink and are heavily used by staff and residents for resident showering. Residents must therefore wait in line to be assisted into the room between showers.

Residents who were interviewed expressed frustration over the process because they have to wake earlier than normal (prior to 0700h) to get into the room before they start showering residents, they sometimes have to wait too long and become uncomfortable and on occasion are not able to remain continent and therefore feeling a loss of dignity. When staff were interviewed to determine if other strategies have been trialled, they stated that due to the limitations of the physical structure of the home, strategies are limited. [s. 51. (1) 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 there are strategies in place to maximize resident's independence, comfort and dignity regarding continence and bowel care, to be implemented voluntarily.***

**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

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

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**Findings/Faits saillants :**

1. The licensee had not ensured that the planned menu items were offered and available at each meal and snack.

a) The planned menu items were not available and offered to Resident #013 at a lunch meal. The planned menu identified a muffin was to be offered as part of the cheese and fruit plate, however, the home ran out of muffins. The resident was provided raisin bread instead of the planned muffin. The muffin shortage was not communicated to the Food Service Manager.

b) Residents receiving tray service were not offered soup, as per the planned lunch menu on November 27, 2012.

c) Resident #998 was not offered an entrée from the planned menu. Staff confirmed the resident was not offered an entrée and that the resident routinely left the dining area prior to finishing meals. The resident was assessed as a high nutritional risk however the Registered Dietitian was not aware that the resident was not consistently being offered a full meal. [s. 71. (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 planned menu items are offered and available at each meal and snack, to be implemented voluntarily.***

**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee had not ensured that the food production system included standardized recipes and production sheets for all menus.

The production sheets and recipe book for Week 2 Monday and Tuesday did not include gluten-free soups; Turkey Rice on Monday and Garden Vegetable on Tuesday. The Cook confirmed the vegetables for the regular soup were used with gluten-free broth to make the gluten-free soups. The Food Services Manager confirmed there were no recipes for gluten-free soups provided and they were not included on the production sheets. [s. 72. (2) (c)]

2. The licensee had not ensured that all menu items were prepared according to the planned menu.

The lunch menu on November 20, 2012 indicated a choice of chicken pot pie. The therapeutic menu, production sheets and recipes indicated that the minced and pureed diets would also receive the pot pie in a minced and pureed consistency. The Cook confirmed that these recipes were not used and that the residents on minced and pureed diets received a blend of chicken and vegetables with mashed potato instead. This resulted in the residents not being offered a grain serving for that meal. [s. 72. (2) (d)]

3. The licensee had not ensured that all food and fluids in the food production system were prepared, stored and served using methods to preserve nutritive value, appearance and food quality.

Pureed menu items were observed at the lunch meal service on November 20 and 27, 2012. The consistencies of the pureed pancakes, fruit and hot vegetable served with the main entrée on November 20, 2012 and the cottage cheese and bran muffin on November 27, 2012 were very thin and runny. This affected the appearance of the meal as the food items ran on the plate and the quality as this was an inappropriate consistency for pureed menu items.

The Food Service Manager confirmed the items above served on November 27, 2012 were too thin and that the recipes had not been followed. [s. 72. (3) (a)]

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*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 standardized recipes and production sheets are available for all menus, that menu items are prepared according to the planned menu and that food and fluids are prepared, stored and served using methods to preserve nutritive value, appearance and food quality, to be implemented voluntarily.*

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**WN #12: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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

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 licensee had not ensured there was a process to ensure that staff assisting the residents were aware of the residents' diets, special needs and preferences.

A staff member assisting a resident with eating lunch was providing a menu item that was not allowed on the resident's diet. The staff member was unable to locate the therapeutic menu and diet list to verify if the resident was able to have the item. The Registered Dietitian confirmed the food item that was provided was not appropriate for that diet order. [s. 73. (1) 5.]

2. The licensee had not ensured proper techniques were used to assist residents with eating.

a) At the lunch meal the staff person assisting Resident #999 with eating was observed scraping the resident's mouth with a spoon to remove food debris as opposed to using a napkin.

b) Staff assisting a resident with medications on the second floor was observed scraping Resident #994's mouth aggressively with a medication cup. [s. 73. (1) 10.]

3. The licensee had not ensured appropriate furnishings in the dining area.

Some residents were noted to be eating at overbed tables in the dining room as opposed to a dining room table. Staff interview confirmed that the residents were eating at overbed tables as there was insufficient space in the dining room. [s. 73. (1) 11.]

4. The licensee had not ensured that every resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

a) Lunch meal service on two dates was observed. Soup and beverages were placed on the table for three residents who required total assistance with eating and one resident who required significant cuing. Staff were not available to assist when the soup or meal was placed. Resident #996, who required total assistance with eating, had a meal plated and covered then placed on the table until staff were available to assist.

b) According to resident plans of care, Residents #710, 703 and 874 required assistance at meal times. These residents were observed at the lunch meal service and it was confirmed that they required assistance to eat. The lunch entrées were served five to fifteen minutes before a staff person was available to assist the resident.

The Food Services Manager confirmed meals should not be served until someone is available to assist the resident. [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 there is a process to ensure staff assisting residents are aware of the resident's diets and special needs, that proper techniques are used to assist residents while eating and that meals are not served until someone is available to provide the assistance required by the resident, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program**

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

**s. 86. (2) The infection prevention and control program must include,**
**(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).**
**(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).**

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**Findings/Faits saillants :**

1. The infection prevention and control program does not include measures to prevent the transmission of infections.

Various practices in the home were observed with respect to the handling of resident personal care devices, supplies and equipment such as nail clippers, bed pans, urinals, washbasins, toothbrushes, tubs and shower/commode chairs. Measures to reduce the risk of infection have not been developed or fully implemented.

a) The current process of using commode chairs for toileting over 24 residents in the tub rooms several times per day poses some infection control risks if staff do not adhere to strict protocols. The home has not developed any specific infection control measures for the handling of waste generated in these tub rooms. Currently, the only option for the disposal of waste by-products according to observations and staff interviews is to carry the commode pot or push the commode chair out of the tub room and around the corner to the soiled utility room where there is a hopper that can be used for disposal. There are several unused tubs located in these tub rooms. One of the two pedestal tubs in one of the tub rooms was heavily soiled with an unknown brown substance which had been dumped into the tub on November 20th. The substance had clogged the drain and was still draining on November 28, 2012. The tub was not cleaned by November 30, 2012.

b) The hand washing program has not specifically captured challenges related to the lack of adequate hand washing sinks. Currently, there is no hand sink available in two of the tub rooms and staff and residents must rely on hand sanitizing gel, which is insufficient when hands are visibly soiled. Staff and residents must leave the area to use sinks located either in their own rooms or use a sink located behind a locked door (for staff).

c) Numerous toothbrushes were identified to be stored in resident washrooms in an unhygienic manner, in direct contact with vanity tops shared by 4 residents. No system was in place to determine which toothbrush belonged to which resident, many had worn bristles, were dirty in appearance or had a lot of encrusted toothpaste on them. No system is currently in place or procedure to monitor the condition of the toothbrushes and to ensure they remain clean and not a source of contamination for residents. [s. 86. (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 the infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.***

**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

1. The licensee had not ensured that all hazardous substances at the home were kept inaccessible to residents at all times.

a) On November 20, 2012 at 1004h, the DeCew House shower room was left unattended with the door open. Hazardous chemicals were found under the sink in an open cupboard.

b) On November 21, 2012 at 1005h the Short Hill tub room was left unlocked, the door was propped open and the room was unattended. There were no staff present when the inspector entered the tub room and staff were still not present at 1017h. In an unlocked and open cupboard, hazardous chemicals were accessible; specifically Arjo Huntleigh Disinfectant cleanser IV (poison and corrosive symbols on the label) and Wood Wyant Total universal cleanser and polish (do not come in contact with skin and toxic symbol on the label).

c) On November 21, 2012, at 1143h the door to DeCew House tub room was left open and unattended with hazardous chemicals accessible to residents. [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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.***

**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

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

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee had not ensured that every release of a physical device and all repositioning was documented for all residents using a physical device as a restraint.

The home used a Restraint Monitoring Record to record when a restraint was applied, removed, checked for safety, when the resident's position changed and when toileted. This record was reviewed for Resident #069 for a three week time period. Some blocks were left blank on the record; there was no information recorded for eight hours during the day shift on two days and no information recorded for eight hours for the evening shift one day. For each of the other evening shifts during this time period the only code used was "A" meaning" applied" with no coding indicating there was a release of the device or repositioning between 1500-2000 when the resident went to bed. The day shift on one day showed no codes indicating a release or repositioning of the resident. According to the plan of care the resident should be repositioned every two hours.

Registered staff interviewed confirmed the repositioning documentation was not completed as per established home procedure. [s. 110. (7) 7.]

*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 every release of a restraint device is documented for all residents, to be implemented voluntarily.*

**WN #16: 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 had not ensured that drugs were stored in an area or a medication cart that was secured and locked.

On November 27, 2012 at 0845 hours, a medication cart was noted to be unlocked and unsupervised outside the first floor tuck shop, with two blister packages of medication accessible. [s. 129. (1) (a)]

2. At the lunch meal November 20, 2012 in the DeCew House dining area, the medication cart was left unlocked and unattended, and the drawers of the cart were left open.

At the lunch meal November 27, 2012 in the Main dining area, the medication cart was positioned in front of the tuck shop and was not visible from the dining room. The cart was left unlocked and unattended while the staff member was distributing medications in the dining area.

The staff member confirmed the cart was left unlocked and this was not an accepted practice at the home. [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 the medication cart is secured and locked, to be implemented voluntarily.***

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

Specifically failed to comply with the following:

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

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 had not ensured that all drugs used by or administered to a resident in the home had been prescribed for the resident.

a) Resident #112 was provided a medication without a physician order. Staff interview confirmed that an order was required for this medication and that an order was not obtained/written. The medication provided was also not documented on the medication administration record as provided to the resident. (107)

b) Resident #705 was given three drugs that were not prescribed. These drugs were prescribed for a different resident and were given in error.

This error was confirmed by the home in a critical incident report submitted by the Executive Director. [s. 131. (1)]

2. The licensee had not ensured drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

The Medication Administration Record (MAR) for Resident #069 indicated an order for a specific medication. According to the MAR this drug was withheld by nursing on a specific date. The MAR indicated a new order for this medication 11 days later at a different dosage, however the resident had not had a dose for 11 days and continued to not receive this medication at the time of this inspection.

Registered staff confirmed the medication was being withheld due to request received from the resident's SDM, however there was no change in the prescriber's orders to stop or withhold the administration of this medication.

The Director of Care confirmed the expectation that medications are not withheld on an on-going basis without an order by the prescribing physician. [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 all drugs used by or administered to a resident are prescribed for the resident and all drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee had not ensured that for a resident taking any drug or combination of drugs, including psychotropics, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

According to the Medication Administration Record (MAR), Resident #013 received 31 PRN (as needed) analgesic medications. According to the MAR, progress notes and staff, the medication was not evaluated for effectiveness at least 21 times. [s. 134. (a)]