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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2014	2014_295556_0021	O-000409-14	Resident Quality Inspection

Licensee/Titulaire de permis

DEEP RIVER AND DISTRICT HOSPITAL
117 BANTING DRIVE, DEEP RIVER, ON, K0J-1P0

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

THE FOUR SEASONS LODGE
117 BANTING DRIVE, DEEP RIVER, ON, K0J-1P0

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

WENDY PATTERSON (556), MEGAN MACPHAIL (551)

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 9, 10, 11, 12, 13, 16, 17, 18, 19, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Chief Financial Officer (CFO), Registered Dietitian, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Housekeeper, Recreation Worker (RW), Physiotherapist, Pharmacist, Volunteer, Resident Council President, Substitute Decision Makers (SDM), and Residents.

During the course of the inspection, the inspector(s) toured resident care areas; observed meal services, nourishment passes, and recreation activities; observed staff to resident, and resident to resident interactions; reviewed health care records, nursing policies, housekeeping policies, staffing schedules, and posted menus.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Trust Accounts

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007, c.8, s.6 (9) 1. in that the licensee did not ensure that the provision of the care set out in the plan of care was documented.

A review of the progress notes indicates that Resident #642 exhibits the responsive behaviour of using dining room chairs, or the chair in his/her room to toilet him/herself.

While observing Resident #642's room Inspector #556 detected an offensive odour coming from the wing back chair and PSW #100 stated that Resident #642 frequently uses the chair to toilet him/herself, and housekeeping can no longer get the odour out of the chair.

The Care Plan for Resident #642 indicates that staff are to ensure that the resident is dry and clean by toileting him/her every two hours.

A review of the Observation / Flow Sheet Monitoring Form on Point of Care for a two week period for Resident #642 was conducted and under the category of toileting there was no documentation on the day shift on two separate days.

PSW #112, stated that the PSW's do not document every 2 hours regarding Resident #642's toileting routine, but there is an expectation that they will document whether the resident has been incontinent or continent of bowel or urine on each shift. [s. 6. (9) 1.]

2. Resident #640 had a swallowing assessment by a Speech and Language Pathologist (SLP) on a specified date. One of the recommendations was "client's mouth to be cleared with sponge after each meal to clear mouth of residue". Resident #640's plan of care states that his/her mouth is to be "swabbed" after each meal.

During the course of the inspection Staff Members #103 and #112 were interviewed by Inspector #551 and each stated that the expected frequency of mouth care for Resident #640 was after each meal. Staff Member #112 stated that if the provision of mouth care was not documented in the morning it meant Resident #640's spouse had done the mouth care.

Over an eleven day period mouth care was to be provided thirty three (33) times. The progress notes and flow sheet were reviewed by Inspector #551 and indicated the provision of mouth care was documented twelve (12) times.

The care set out in the plan of care was not documented as it relates to the provision of mouth care. [s. 6. (9) 1.]

3. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 6 (10) (b) in that the licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time, when the resident's care needs change.

Resident #647 was admitted to the home on a specific date and according to the Nutrition Care Plan was assessed as being at high nutritional risk.

The Registered Dietitian (RD) was interviewed on June 11, 2014 and stated that the following nutritional interventions were implemented for Resident #647: texture changed to puree; Ensure three times per day (tid) with meals and high calorie/protein diet.

Resident #647 experienced significant weight loss of 6.4% (3.2kg) over a 30 day period resulting in a weight of 46.6kg, 17.9kg below his/her ideal body weight range of "64.5-67.2kg"(according to the Nutrition Care Plan) and represented a Body Mass Index of 17.3.

The weight of 46.6kg represented a loss of 7.9% (4kg) over a 3 month period, - 8.9%

(4.6kg) over a 6 month period, and - 21.3% 12.6kg over a 1 year period.

Resident #647's health care record was reviewed. The last progress note entry addressing Resident #647's weight status by the RD was approximately 20 days prior to when the 46.6 weight measurement was taken.

Resident #647 was not reassessed and the plan of care was not reviewed and revised when Resident #647's care needs changed as evidenced by significant weight loss of 6.4% (3.2kg) over a one month period. [s. 6. (10) (b)]

4. Resident #650 was admitted to the home on a specific date.

Resident #650 experienced weight loss of 8.5% (6.6kg) over a specified six week period. His/her weight further declined 2.8% (2kg) over the next 30 days resulting in a weight of 71.3kg which represented a loss of 12.4% (10.1kg) over a three month period.

Resident #650 was assessed by the RD on a specified date at which time weight loss of "10.7kg/3months (23.5lbs) secondary poor appetite, illnesses" was noted. A high calorie/protein diet and Ensure twice daily were implemented.

Resident #650 was not reassessed and the plan of care was not reviewed and revised when Resident #650's care needs changed as evidenced by weight loss of 8.5% (6.6) over a one month period and – 12.4% (10.1kg) over a three month period. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the provision of the care set out in the plan of care is documented; and that residents are reassessed and the plan of care reviewed and revised when care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 37 (1) (a) in that the licensee did not ensure that each resident of the home had his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

During Stage One of the Resident Quality Inspection (RQI), the following unlabelled personal care items were observed:

- Tooth brushes in a shared washroom for Resident #651 and #650 were not labelled.

- An electric toothbrush, and towels and face cloths hanging on a rack in a shared washroom for resident #641 and #642 were not labelled.

- In a shared washroom for Resident #644 and #649, one tooth brush, and two soap dishes sitting on top of one another, containing three bars of soap were not labelled. Towels and face cloths hanging on a towel rack were not labelled.

- In a shared washroom for Resident #654 and Resident #781, the following items were not labelled: a pair of scissors, a disposable razor, a bar of soap, a disposable toothbrush and an electric toothbrush

- Resident #654's urine is reported to be MRSA (+). An unsealed urinal was hooked onto the rail beside the toilet in a washroom shared by Resident #654 and Resident #781.

- In a shared washroom for Resident #028 and #653, a towel and facecloth were hanging on a towel rack with no label to identify who the items belonged to.

On June 19, 2014, the Acting Director of Care (DOC) was interviewed and stated that it was expected that all personal care items be labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has his/her personal items labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #3: 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 has failed to comply with Ontario Regulation 79/10, s. 134 (a) in that the licensee did not ensure that 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.

Resident #642 demonstrates the responsive behaviours of wandering, verbal abuse, physical abuse, resisting treatment or refusing care, agitation, and inappropriate social behaviour. Medications have been prescribed as part of the plan to manage the responsive behaviours. The Psychogeriatric Outreach Team has been monitoring the resident and has made recommendations regarding medication changes and/or dosage changes on four separate months.

A review of the progress notes in the Resident’s health care record was conducted and indicate that the following PRN medications were administered to Resident #264 without noting the effectiveness of the medication: a specific narcotic analgesic X 2 separate times, a specific antidepressant X 5 separate times, a specific analgesic X 1,and a specific antipsychotic X 1.

In an interview the Acting DOC stated that the home's process is to document the response and effectiveness of PRN medication in the progress notes. [s. 134. (a)]

2. Resident #651 was admitted to the home on a specified date. She/he was ordered a specified antipsychotic medication as needed.

Resident #651's health care record was reviewed and indicated that staff Member #117 administered a specified antipsychotic medication and stated "given for c/o unable to sleep". There is no further documentation to support that the resident's response to, and the effectiveness of the administration of the antipsychotic medication was monitored. [s. 134. (a)]

3. Resident #641 was admitted to the home on a specific date. She/he was followed by the Renfrew Geriatric Mental Health Outreach Program (Pembroke Regional Hospital).

On June 17, 2014, Staff Member #101 was interviewed and stated that resident exhibits responsive behaviours in the form of calling out. On June 12, 2014, Staff Member #103 stated that Registered Staff are expected to document the effectiveness of the administration of an as needed (prn) medication, and that the Mede-Care system would generate a prompt to signal that a follow-up was required.

Resident #641's health care record was reviewed and shows that she/he was ordered a specified antipsychotic medication every four hours as needed (prn), as well as a specified antipsychotic medication twice per day (bid). On on a specified date, the specified antipsychotic medication that had been ordered in the morning and as needed (prn) was discontinued and a different specified antipsychotic medication at bedtime (hs) was ordered.

Resident #641's progress notes were reviewed and indicate that prn medications were administered on three separate occasions without documentation to support that Resident #641’s response to, and the effectiveness of the medication were monitored.

On a specific date and time: a specified antipsychotic "to decrease shouting".
On a specific date and time: "a specified antipsychotic to promote rest".
On a specific date and time: a specified antipsychotic "to promote rest". [s. 134. (a)]

4. Resident #654 was admitted to the home on a specific date. For pain, he/she was ordered an opioid every 12 hours, and an opioid 4 times a day when required (prn) and an analgesic 4 times a day when required (prn).

Resident #654's health care record was reviewed over a two week period, and according to the Progress Notes Resident #654 received the following PRN medications for pain:
a specified opioid for "c/o right hip pain" X 4,
a specified opioid for "c/o shoulder pain" X 3,
a specified opioid for c/o knee pain".
a specified opioid for "c/o pain".

Over a two week period a PRN medication for pain was administered nine times. There is no documentation to support that the resident's response to, and the effectiveness of the administration the medications were monitored. [s. 134. (a)]

5. Resident #651 was admitted to the home on a specified date. She/he was ordered an analgesic every four hours as needed.

Resident #651's health care record was reviewed and the progress notes indicated that Staff Member #115 wrote the following progress note "Res c/o back pain; a specified anagesic by mouth (po) given at a specified time; will monitor".

There is no further documentation to support that the resident's response was monitored. [s. 134. (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

s. 241. (5) Every licensee shall establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,
(a) a system to record the written authorizations required under subsection (8); and O. Reg. 79/10, s. 241 (5).
(b) the hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money. O. Reg. 79/10, s. 241 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10 s. 241 (1) in that the licensee did not ensure that all money entrusted to the licensee's care on behalf of a resident were deposited into a non-interest bearing trust account at a financial institution.

In an interview Resident #653's Substitute Decision Maker (SDM) stated that the home doesn't deposit his/her parent's money in a bank account, it is kept right at the nurses station in an envelope.

In an interview RPN staff member #103 stated that the petty cash is locked in the medication room. The cash is kept in a folder and each resident has an envelope in the folder and a form entitled petty cash record where the deposits and withdrawals to the Resident’s envelope are recorded.

In an interview the Chief Financial Officer (CFO) stated that the home has a trust account established at a financial institution however only one resident has money in the trust account, all other monies given to the home by Residents / SDMs are held and managed through an envelope system in the Long Term Care Home that is referred to as the petty cash. The CFO further stated that the petty cash is not petty cash trust money; it is each resident's individual envelope of petty cash. [s. 241. (1)]

2. The licensee has failed to comply with Ontario Regulation 79/10 s. 241 (5) in that the licensee did not establish a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which includes,
(a) A system to record the written authorizations required under subsection (8); and
(b) The hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident’s funds in a trust account and make withdrawals from the petty cash trust money.

In an interview the Acting DOC stated she/he cannot locate a written policy and procedures for the management of resident trust accounts; however she/he was able to provide a copy of the policy and procedure entitled Petty Cash for Residents #P-007 last reviewed September 2012. The policy states that "each resident is encouraged to maintain petty cash at the home for incidental expenses such as foot care, hair care, etc. The Home shall accurately maintain the monies. Petty cash monies will be kept locked in the medication room. Deposits, withdrawals and balances will be maintained on the petty cash form".

The CFO stated she/he was not aware of the home having a written policy and procedures for the management of resident trust accounts and the petty cash trust money. [s. 241. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all money entrusted to the licensee's care on behalf of a resident are deposited into a non-interest bearing trust account at a financial institution; and a written policy and procedures for the management of resident trust accounts and the petty cash trust money, which must include,
(a) A system to record the written authorizations required under subsection (8); and
(b) The hours when the resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10, s. 27 (1) (a) in that the licensee did not ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

In an interview one of the Substitute Decision Maker's (SDM) stated that neither of the SDM's had been invited to attend a six week care conference following Resident #653's admission on a specified date.

In an interview RPN staff member #110 stated that when a care conference is conducted it is documented in the progress notes. A review of the progress notes compiled during the first eight weeks Resident #653 resided in the home was conducted and there was no indication that a six week care conference had been conducted for Resident #653.

In an interview RPN staff member #101, and RPN staff member #103, who are the two full time registered staff in the home stated that six week care conferences have not been conducted for any of the residents in the home because they were unaware that it was a requirement. [s. 27. (1)]

WN #6: 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).

Findings/Faits saillants :

1. The LTCHA 2007, c 8, s. 10. (1) states that every licensee of a long-term care home shall ensure that there is an organized program of recreational and social activities for the home to meet the interests of the residents, and the Ontario Regulation 79/10 section 30 (1) 3 & 4 under the heading of General Requirements for Programs states that the program must be evaluated and updated at lease annually, and a written record relating to each evaluation must be kept.

The policy entitled Recreation and Leisure Services R-005, which contains the written description of the program for recreational and social activities, was reviewed and it was noted that the last review date was September 2012. In an interview recreation staff member #107 stated that the September 2012 review date is the most up to date version of the policy. Staff member #107 also stated that she/he is not aware of any written record relating to the September 2012 program evaluation.

The Acting DOC, who stated that she/he is currently the lead for the Recreational and Social Activities Program for the home, was not able to provide evidence that the program was evaluated and updated since the September 2012 review, nor was she/he able to provide the written record relating to the September 2012 review. [s. 30. (1) 1.]

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. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10, s. 34 (1) (a) in that the licensee did not ensure that resident #644 received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening.

The plan of care for Resident #644 indicates she/he has her/his own teeth, and that staff are to assess her/his oral cavity daily for any obvious sores or deterioration of teeth and gums, and provide mouth care daily, and as required. The plan of care further indicates that she/he is not able to provide her/his own mouth care.

A review of the flow sheet for Resident #644 regarding mouth care provided indicates that between June 1 and June 16, 2014 Resident #644 received mouth care once a day on 11 separate days.

PSW #116 stated that Resident #644 has gingivitis which causes mouth pain, and as a result when she/he is working she/he tries to give Resident #644 extra mouth care.

In an interview RPN #101 stated that the expectation in the home is that mouth care is provided in the morning, at bedtime, and then as required. RPN #101 further stated it was an oversight that Resident #644's plan of care indicated she/he was to have mouth care only once daily. [s. 34. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The LTCHA 2007, c 8, s. 15. (1) (a) states that every licensee of a long-term care home shall ensure that there is an organized program of housekeeping for the home; and the Ontario Regulation 79/10 section 87 (2) (d) states that as part of the organized program of housekeeping the licensee shall ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The licensee has failed to comply with Ontario Regulation 79/10, s. 87 (2) (d) in that the licensee did not ensure that a procedure for addressing incidents of lingering offensive odours was developed and implemented to address the odours in Resident #642's room.

While in the corridor of the home Inspector #556 detected an offensive odour coming from the resident's room. Upon entering the room Inspector #556 determined that the odour was from the wing back chair.

A review of the progress notes in Resident #642's health care record indicated that she/he was frequently incontinent of both urine and feces on the wing back chair in her/his room.

PSW #100 stated that "Resident #642 uses the wing back chair in her/his room when she/he has to go to the toilet, and because it has happened so many times housekeeping is no longer able to get the smell out".

In an interview Housekeeper #122 stated it is housekeeping's responsibility to clean Resident #642's chair, however even though housekeeping cleans the chair with a steam cleaner it is now impossible to get the smell out due to the frequency that the chair is soiled. Staff member #122 further stated that they have two types of deodorizer but neither is effective to eliminate odour on a chair. Staff member #122 further stated that the home doesn't have a policy or procedures to address odours.

Inspector #556 reviewed the policy and procedure manual for the housekeeping department and there was no policy or procedure for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10, s. 136 (3) (b) (ii) in that the licensee has failed to ensure that non controlled drugs and substances must be destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the DOC and one other staff member also appointed by the DOC.

In an interview Registered staff #103 stated that when a non controlled drugs need to be disposed of the RPN on duty, acting alone, puts the medication in the designated disposal container that is kept in the medication room. She/he further stated that two staff are only involved in the process if the drug is a narcotic.

A review of the homes Drug Disposal policy revision date September 2012, D-055 stated discontinued, unused, expired, recalled, deteriorated, unlabeled drugs and containers with worn, illegible, damaged, incomplete or missing labels shall be removed from current medication supplies, and returned to pharmacy for destruction. The policy does not state that one member of the registered nursing staff appointed by the DOC and one other staff member also appointed by the DOC are to be involved in the process of destroying non controlled drugs and substances. [s. 136. (3) (b)]

WN #10: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with Ontario Regulation 79/10, s. 229 (10) (3) in that the licensee did not ensure that residents must be offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Resident #654 was admitted to the home on a specified date. His/her health care record was reviewed by Inspector #551, and RPN #101 and there is no documentation to support that he/she was offered immunization against tetanus and diphtheria. [s. 229. (10) 3.]

Issued on this 10th day of July, 2014

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