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 30, 2014	2014_271532_0021	L-000673-14	Resident Quality Inspection

Licensee/Titulaire de permis

EDEN HOUSE CARE FACILITY INC
R.R. #2, GUELPH, ON, N1H-6H8

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

EDEN HOUSE NURSING HOME
5016 Wellington County Road 29, R. R. #2, GUELPH, ON, N1H-6H8

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

NUZHAT UDDIN (532), DEBORA SAVILLE (192), TAMMY SZYMANOWSKI (165)

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 16, 17, 18, 19, 20, 24, 25, 2014

Inspected CIS L-000523-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument(RAI) Cooridnator ,Housekeeping Supervisor , Maintenance Supervisor, Registered Dietitian, Program Director, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Family and Resident Council Representatives, 40+ Residents and 4+ Family Members.

During the course of the inspection, the inspector(s) toured the resident home areas and common areas, medication rooms, the servery, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home

The following Inspection Protocols were used during this inspection:

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

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. (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. (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).

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 of the long term care home failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A) Throughout the inspection a resident was observed to be in a mobility device. Staff interviewed confirmed that the resident was capable of getting out of the mobility device and that it was used for positioning and comfort. The DOC confirmed that the mobility device would be considered a Personal Assistance Services Device (PASD) without restraining properties. The DOC reported that the PASD should be included in the plan of care along with the expectations for staff to reposition the resident at least every two hours. The DOC confirmed there was no plan of care developed to include the use of the PASD.

B) Review of the clinical health record and interviews with the Physiotherapist and Physiotherapist Assistant (PTA) confirmed that a resident was receiving a treatment provided by the PTA. The PTA confirmed that a plan of care was not developed that included the treatment program however; the Resident Assessment Instrument (RAI) Co-ordinator and the DOC confirmed that it was the expectation of the home that the care provided by the PTA would be set out in the planned care for the resident. [s. 6.

(1) (a)]

2. The licensee failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

A) The plan of care for a resident indicated that staff were to check and change the resident routinely to avoid sitting in a wet brief. It was observed that the resident was not checked nor changed by staff routinely. A Personal Support Worker confirmed the resident was last checked and changed early in the morning and would be checked, toileted and changed in the afternoon and that this was the resident's normal routine. Observations confirmed that the resident was not checked nor changed for an extended period of time, however; the Resident Assessment Instrument Co-ordinator confirmed that the resident should have been checked routinely as indicated in the plan. (165)

B)The plan of care for a resident indicated that staff were to toilet the resident routinely each day. Clinical record indicated that the resident's toileting plan was effective. Personal Support Workers on two shifts stated that the resident was not on a scheduled toileting plan and confirmed that the resident was not toileted as specified in the plan. (165)

C) Review of clinical record stated that a resident was at high risk for altered skin integrity.
A resident was identified as having impaired skin and the plan of care indicated that the registered nursing staff were to complete weekly wound assessments. A Registered Practical Nurse confirmed that there were no weekly assessments completed as specified in the plan of care. (532)

D) The plan of care for a resident indicated that the resident was to have extensive assistance with the activities of daily living.
The resident was observed at two different occasions with dirty face and facial hair on their chin. Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that the resident's face was unclean and had not been shaven. Interview indicated that electronic documentation directs the staff to shave the resident on their bath days and that staff who assist the resident with eating were responsible for washing the residents face. A review of the electronic documentation confirmed that the resident did not receive a shave and care was not provided as set out in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change.

A) The clinical record indicated that the resident preferred a tub bath. PSWs interviewed indicated that the resident currently received a shower as the resident was not safe to have a tub bath. The resident stated they received showers and was not informed that tub baths would not be safe. Electronic documentation indicated the resident received showers. The resident's plan of care was not revised when the resident's care needs changed for bathing.(165)

B) The plan of care for a resident stated that staff were to ensure that an adaptive device was in place when the resident was up in wheelchair. Observations indicated that the resident was not wearing the adaptive device as stated in the plan of care. PSW staff member confirmed that the resident no longer wears the adaptive device and instead uses an alternative. RAI co-ordinator confirmed that staff stopped using the adaptive device and instead were using an alternative, however, the plan of care was not revised when the resident's care needs changed or care set out in the plan was no longer necessary. (532)

C) A review of the plan of care indicated that a resident required daily oral care related to dentures. Through interview it was determined that the specific care related to dentures was no longer necessary and the interview with the registered staff confirmed that the plan of care should have been revised to reflect this change. [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 to ensure that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.
A) Following were observed during a tour of the home:
- The activation room was observed to have black soil and debris in the corners and scuff marks on the floor near the Piano.
- The shower room tiles were observed as blackened and worn off, dirty baseboards and caulking along the shower room was worn off and blackened from dirt, black dirt built up in the corners and by the entrance to the tub room.
B) An identified room was observed to have black loose debris on the floor and at the edges of the room.
C) Following were observed during a tour of the home with the maintenance and housekeeping supervisor:
- Identified rooms had cracked floor tiles and grooves that made the room uneven and unsafe for residents.
- Identified rooms had bathroom tiles that were stained behind the toilet.
- Identified room had cracked floor tiles.
- Identified room had missing door casing guard.
- Identified room had blackened floor tiles at the entrance.
- Identified room had cracked bathroom tiles.
- Identified room had a spider web and ants behind the door, a dirty Kleenex and black soil debris on the floor.
- Behind the activity room door a spider web with insects was observed and black debris noted on the floor.
The above observations were confirmed with both the maintenance and the housekeeping supervisor. Housekeeping supervisor confirmed that the rooms were not mopped that day and the deep cleaning of the rooms were not done until residents were discharged from the home. [s. 15. (2) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) A resident reported that they were not bathed twice a week but would prefer a second shower or a bath. The current plan of care indicated that the resident preferred showers in the evening. PSW staff and the bathing schedule confirmed that the resident was receiving one shower in the afternoon and the second bath as a sponge bath.(532)

B) A review of the bath schedule indicated that a resident was receiving one sponge bath and one shower. In an interview a PSW staff confirmed that the resident was receiving only one shower a week. Review of clinical record stated that the resident was to receive a shower twice weekly due to resident's altered skin integrity. (532)

C) A resident stated that they were offered one shower and received a sponge bath as the second method of bathing per week. The resident confirmed that they would prefer to have a second shower rather than a sponge bath that was currently being provided. The bath schedule and PSWs confirmed that the resident received one shower and one sponge bath per week. PSWs confirmed that residents were only offered one bath or shower per week and sponge baths were provided unless the resident specifically requested a second bath or shower.
Director of Care confirmed that all residents should be bathed, at a minimum, twice a week by the method of their choice. [s. 33. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of a between meal beverage in the morning.

A) A resident was not offered a beverage off the nourishment cart and a PSW confirmed that the resident was missed during the delivery. A review of clinical record indicated that the resident was at risk for dehydration.

B) A resident did not receive a beverage from the nourishment cart. A PSW confirmed that beverage was not offered to the resident. A review of the clinical health record indicated the resident was at risk for dehydration and required assistance with drinking. [s. 71. (3) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)

Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded in respect of every drug that is ordered and received in the home.

A) Clinical record indicated that medications were ordered for various residents on identified dates. The medications ordered were not documented to have been received in the home, there was no signature and no prescription number documented. Clinical record on identified dates indicated that medications were ordered for various residents and included controlled substances. None of the medications ordered were documented to have been received by the home, there was no signature and no prescription number. Clinical record indicated that three medications were ordered for a resident and these medications were not documented to have been received by the home, there is no signature and no prescription number documented. Additional medications were ordered that were not documented as having been received by the home. Interview with the Director of Care confirmed that all medications ordered should have documented. The DOC also confirmed that the clinical record was incomplete and that the home had recently identified some challenges with incomplete documentation. [s. 133.]

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 a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home, to be implemented voluntarily.

WN #6: 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).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that where a drug that was to be destroyed was not a controlled substance, it was done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing.

A) It was confirmed by registered staff and the Director of Care that the current practice for drug destruction, when the drug was not a controlled substance, was for one registered staff member to dispose of the medication in a white pail located in the storage room off the medication room. The Director of Care confirmed that the policy in use in the home was from the pharmacy provider which indicated that with the exception of controlled substances, medications designated for disposal are destroyed at the home by a team of individuals comprised of a registered staff member and another staff member, both of whom were appointed by the Director of Care, and that this policy was not currently being complied with. Drugs that are not a controlled substance are not being destroyed by a team acting together. [s. 136. (3) (b)]

2. The licensee failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption wa rendered impossible or improbable.

A) It was observed that the white pail located in the storage room off the medication room, contained drugs that had been discarded including various tablets, and liquid medications in containers. The medications had not been denatured when they were discarded. This was confirmed by the Director of Care who then added outdated liquid medication to the pail. [s. 136. (6)]

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 where a drug that is to be destroyed is not a controlled substance, it is done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #7: 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs.

A) A Resident was observed to have dirty and uncombed hair. It was documented that the resident received a sponge bath on a identified date. The resident was washed frequently but received a shampoo only once a week on a shower day.

B) A resident was observed to have food on their face. During observation the resident was participating in a group activity program and was noted to have an unwashed face. Interview with the Director of Care confirmed that the resident's face was dirty with dried food on their upper lip. The Director of Care also indicated that the PSW assisting the resident with their breakfast and nourishments would be responsible to ensure that the residents face was clean.

C) On identified dates a resident was observed to have unclean face. A PSW confirmed that the face was not clean and stated that face could not be cleaned as the resident's skin was fragile. The Director of Care stated that resident's face could be cleaned with warm compress and confirmed that the resident was not groomed and cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

WN #8: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) A policy used by the home related to Medication Disposal - Narcotics/LTCH's indicated that for all narcotic and controlled drugs that are to be destroyed; in the presence of two registered personnel, the remaining quantity of the drug is circled on the individual count sheet, the reason for destruction documented and each of the two registered personnel sign and date the form in the spaces provided. Clinical record for medications destroyed in the home were reviewed and it was identified that the clinical record did not include the signatures of two staff of the home before the medication was discarded.
It was identified that the clinical record had only one nurse's signature.
It was identified that 66 percent of the destroyed narcotics did not identify the reason for destruction.
The Director of Care and Pharmacy Consultant confirmed that for all narcotic and controlled drugs to be destroyed by two registered personnel should document the remaining quantity of the drug, the reason for destruction, and each of the two registered personnel should sign and date the form in the spaces provided. [s. 8. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

A) Clinical record review for a resident indicated that the resident prefers to get up at a particular time. In an interview the resident stated that they preferred to get up a little later but shared that the home has a rule of getting up at a certain time and confirmed that resident gets up earlier than the preferred time. A PSW staff confirmed that they get the resident up earlier than their preferred time. The Director of Care confirmed the expectation that resident would stay in bed and get up at the preferred time. [s. 41.]

WN #10: 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 license failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of clinical record stated that an identified resident had impaired skin and was receiving a treatment.
An RPN identified that resident was at high risk for altered skin integrity. RPN confirmed that there was no skin assessment being completed by the registered nursing staff, using a clinically appropriate assessment instrument for the identified altered skin integrity. [s. 50. (2) (b) (i)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

A) During an observation it was identified that a medication that had passed its documented expiration date, was stored on a shelf in the storage room off the medication room. The Director of Care confirmed that the medication was outdated and disposed of the medication in the presence of the inspector. [s. 129. (1) (a) (iv)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program.

A) During an observation of the medication pass it was identified that a resident had been diagnosed with an infectious disease and was being treated. The registered staff member indicated during interview that all staff were made aware of the presence of the infection through the shift report and communication binder and that precautions were in place to protect staff and other residents of the home. During an interview with the Personal Support Worker (PSW) responsible for the care of the resident identified that they were not aware of any infectious disease the resident may have. A registered staff member during an interview stated that they were not aware that the resident was being treated for an infectin. The registered staff member indicated that when a resident has an infection that puts staff or other residents at risk precautions would be initiated including signage, the use of Personal Protective Equipment (PPE) and ongoing communication with all staff.
Interview with the Director of Care confirmed that when a resident has an infectious disease signage should be used to notify all staff of the home. A station should be set up to make PPE available for staff caring for the resident and a note should be included in the Communication Book used to notify PSW's of changes in resident condition. It was confirmed that there was a note in the Communication Book.
The staff of the home failed to participate in the implementation of the infection prevention and control program when the resident was diagnosed with an infectious disease.[s. 229. (4)]

Issued on this 16th day of July, 2014

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