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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2015	2015_378116_0001	T-032-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE GIBSON LONG TERM CARE CENTRE
1925 STEELES AVENUE EAST NORTH YORK ON M2H 2H3

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

SARAN DANIEL-DODD (116), JOANNE ZAHUR (589), JOELLE TAILLEFER (211), SARAH KENNEDY (605)

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): January 12, 13, 14, 15, 16, 19, 20, 21, 23, 2015.

The following inspections were conducted concurrently with the resident quality inspection (RQI): complaint inspections(log #T-160-14 and T-1431-14) and follow up inspections (log T-738-14 and T-1198-14).

During the course of the inspection, the inspector(s) spoke with the Administrator, director of resident services (DORS), assistant director of care (ADOC), resident assessment instrument-minimum data set (RAI-MDS) coordinator, registered dietitian, program and support manager, environmental manager, family services manager, business manager, maintenance aid, registered staff, personal support workers (PSW), families and residents.

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
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

12 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_370162_0001	116

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 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

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

On two separate occasions, the inspector observed a specimen collection hat stored on the floor behind the toilet of an identified shared resident bathroom.
An interview with a personal support worker (PSW) revealed that the home's expectation is that specimen collection hats are for single use and to be discarded after use.
Interview with an identified registered staff confirmed that the above mentioned specimen collection hat is a single use item and once used is to be discarded and not stored on the bathroom floor. [s. 229. (4)]

2. The written plan of care for resident #020 confirms the resident has a colonized antibiotic resistant organism (ARO).
The interventions in place to prevent transmission of the organism instruct staff members to use contact precautions for direct care. Personal protective equipment (PPE) are to be used (gown, gloves and mask) and if needed goggles for splashing.

On an identified date, during an interview with a PSW it was revealed that over the period of one week he/she has only been using gloves when providing care to resident #020 as the resident dislikes the use of PPE's. The PSW was unaware of the purpose for the use of PPE's with the resident.

Interviews with registered staff members, DORS, ADOC and further interview with the PSW confirmed that PPE's should be used at all times when rendering care to resident #020. [s. 229. (4)]

3. Review of the home's policy titled "Routine Practices and Additional Precautions" #LTCE-INF-C-07, dated August 2012, states that PPE -gloves and gown are required for activities that involve direct care (e.g. bathing, washing, turning residents, changing clothes, continence care, wound care, toileting) where the health care provider's skin or clothing may come in direct contact with the resident or items in the resident's room or bed space.

On an identified date, the inspector observed an isolation signage posted on resident #006's door and an identified registered staff member providing treatment to the resident without wearing the appropriate PPE.

Record review of the written plan of care indicated that the resident is colonized with an ARO. Interview with the identified registered staff revealed that skin care treatment was provided to the resident and the PPE should have been worn. Interview with the DORS confirmed that PPE must be worn with contact isolation. [s. 229. (4)]

4. The licensee failed to ensure that staff was screened for tuberculosis in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices that are sustained in the home policy whereby, all new employees being hired must submit copies of the results of a two- step tuberculin skin test (TST).

The following non-compliance was issued on September 15, 2014, during inspection #2014_189120_0055, log #T-387-14 and remains outstanding.

The Canadian Tuberculosis Standards, 7th edition, Chapter 4: Diagnosis of Latent Tuberculosis Infection" dated February 2014, identifies that a two-step tuberculin skin test (TST) should be performed if subsequent TSTs will be conducted at regular intervals. This is to reduce the chance of a false-positive TST conversion when the TST is repeated. The two-step protocol needs to be performed once only if properly performed and documented. Any subsequent TST can be one step, regardless of how long it has been since the last TST.

Review of the current Toronto Public Health directive entitled "Recommendation for

Tuberculosis (TB) Screening in long term care homes for employees and volunteers" updated February 14, 2013, indicates that an assessment for employees and volunteers with unknown TST must receive a two-step TST initiated within six months before starting work or within 14 days of starting work. A person needs to receive a one-step TST if the previous documented results of previous two-step TST was done over six months. A person does not need further testing if both previous two-step TST were negative and was done less than six months ago.

Review of the home's policy titled "Tuberculosis Screening for Staff" (# LTC-CA-WQ-205-05-05, revised in January 2015), documents that all new employees being hired must submit copies of the results of a two- step TST (Mantoux test) completed within the last six months.

Review of the Licensee Confirmation Checklist for Infection Prevention and Control signed by the director of resident services (DORS) indicated that staff are screened with "two-step" TB test (TST) and a follow-up chest x ray if the result is positive.

Record review of a new employee hired on an identified date, and interview with the administrator revealed that the employee submitted a copy of a one-step TB. Interview with the administrator confirmed that the home does not have any supporting documentation to confirm that the new employee has received a two- step TST (Mantoux test) in the past to confirm TST result. [s. 229. (10) 5.]

5. The licensee has failed to ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunization.

Review of the certification of vaccination for an in-house pet indicated that the animal has been vaccinated in 2012 and two visiting pets did not have up-to-date immunization records.

Interview with the DORS confirmed that the in-house pet should have been vaccinated yearly and the immunization was not up-to-date and that two of visiting pets should have up-to date immunization information records. [s. 229. (12)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

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. (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 has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 has an identified diagnosis of mental illness and as per the written plan of care is able to provide his/her personal care independently with minimal assistance. The written plan of care documents that resident #001 does not want staff to stay in the room or touch him/her while he/she conducts his/her personal care.

Interviews with registered staff and personal support workers confirmed that the resident is able to provide his/her oral care independently and becomes provoked if staff attempt to provide assistance.

Review of the health record and interviews with staff confirmed that the plan of care does not set out any directions regarding oral care for resident #001. [s. 6. (1) (c)]

2. Review of the written plan of care for resident #006 indicated that one quarter size bed rail should be used as a personal assistive device (PASD) for bed mobility on the left side and one quarter size side rail should not be in use on the right.

On a specified date, the inspector observed the right side bed rail elevated and in an upright position. On a separate occasion, the inspector observed resident #006 lying in bed with both side rails elevated in an up-down position.

Interviews with an identified PSW and two identified registered staff members revealed that the resident is using both side rails in an up-down position when he/she is in bed and the plan of care does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

The written plan of care for resident #020 documents that the resident has an identified ARO and directs staff to use contact precautions and PPE's for all direct care.

On an identified date, an identified PSW confirmed that he/she has only been using gloves while rendering care to the resident over a specified week as the resident dislikes the use of PPE's.
Interviews held with a registered staff member, DORS, ADOC and further interview with the PSW confirmed that the required PPEs (gloves, mask and gown) are to be used at all times when providing direct care to resident #020. [s. 6. (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 that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be used by residents, staff and visitors at all times.

On two separate occasions throughout the inspection, the inspector observed resident #042's communication and response system not functioning at the bedside. On both incidences, two identified staff members were notified respectively.
An interview was held with an identified PSW on a specified date, during which it was mentioned that the resident's communication system was functioning on the previous day.

An interview with the administrator confirmed that the resident's communication and response system was repaired on the day that he/she was informed by the staff. [s. 17. (1) (a)]

2. On an identified date, the inspector observed resident #043's communication and response system not functioning at the bedside. An identified staff member was notified.

Review of the maintenance request log indicated that the resident's communication and response system was repaired the following day [s. 17. (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 the home is equipped with a resident-staff communication and response system that can be used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the public inspection reports from the past two years for the long-term care home are posted in the home.

During the inspection, the inspector observed the following inspection reports were not posted in the home:

inspection #2013_162109_0025 conducted on June 4, 2013
inspection #2013_168202_0012 conducted on February 25, 2013
inspection #2013_219211_0002 conducted on February 27, 2013
inspection #2013_162109_0002 conducted on January 28, 2013.
The absence of the reports was confirmed in an interview with the DORS. [s. 79. (3) (k)]

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 copies of the public inspection reports from the past two years for the long-term care home are posted in the home, to be implemented voluntarily.

WN #5: 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 licensee has failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

On several occasions, throughout the duration of the inspection, lingering offensive odours were noted in resident #011's bedroom and washroom.
Interviews held with resident #011's substitute decision-maker (SDM), registered staff, PSWs and housekeeping staff confirmed that the offensive odours were prevalent and an ongoing issue in the residents' bedroom and washroom. Furthermore, staff confirmed that the offensive odours were brought to the attention of the environmental manager on different occasions.
Despite measures taken by housekeeping staff to eliminate the odours in the room, the odours are still prevalent.
On an identified date, the administrator confirmed the presence of lingering odours in resident #011's bathroom and that additional measures to replace the floor were being put in place to address the identified odours. [s. 87. (2) (d)]

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 procedures are implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified date, the inspector observed pre-poured, unlabelled medications for the following residents stored in a medication cart on an identified unit:
- three white pills stored in a white medication cup within resident #021's medication bin
- crushed medications stored in resident #022's medication bin
- half of a tablet stored in the top drawer within stock medications for resident #023.

The registered staff member assigned to the medication cart confirmed the pre-pouring of the medications and signing the medication administration record (MAR) indicating that the medications had been administered to the residents.

On a separate occasion, the inspector observed unlabelled, pre-poured medications for the following residents stored in a medication cart of an identified unit:
-a red pill stored in a medication cup within resident #024's medication bin
- a white pill stored in resident #025's medication bin
- a white pill stored in resident #028's medication bin
- a white pill stored in resident #026's medication bin
- pink liquid in a white medication cup stored in resident #027's medication bin

An interview was held with the assigned registered staff member revealed that the pre-poured medications for resident #025 and resident #028 are controlled substances that are required to be stored in a separate locked area within the locked medication cart.

Interviews held with the assigned registered staff members, DORS and administrator confirmed that medications should remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #7: 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 has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date, the inspector observed a pre-poured controlled substance prescribed for resident #'s 025 and #028 stored within medication bins of an identified medication cart. The assigned registered staff member confirmed to the inspector that pre-pouring the medications made it easier to facilitate administration. Further interviews with the registered staff member, DORS and administrator confirmed that all controlled substances are to be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart until administration. [s. 129. (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 that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

On an identified date, in an identified dining room, the inspector observed that a long electric cord was hanging from the ceiling fan reaching the floor.

Interview with an identified registered staff revealed that the hanging electric cord was a safety hazard.

Interviews with the maintenance services manager and the administrator confirmed that the hanging electric cord from the ceiling fan reaching the floor was a safety hazard for the residents. [s. 5.]

WN #9: 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 has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

Interview with resident #031 revealed that staff are frequently telling him/her to turn his/her light off and go to sleep when he/she would prefer to read in bed.

An identified PSW confirmed that sometimes resident #031 is told to go to sleep instead of reading.

A review of the plan of care for the above resident revealed that his/her sleep patterns and preferences are not identified in the written plan of care.

Interview with the DORS confirmed that if a resident prefers to read in bed that this should be in the care plan so that staff are aware of the residents' preferences and sleep patterns. [s. 26. (3) 21.]

2. During an interview with resident #020 he/she expressed that he/she prefers to retire for the night at an established time and that on a specified date, staff members were late which resulted in him/her going to bed one hour after the established time. The resident expressed this occurs frequently.

Record review revealed and interviews with registered staff and PSWs confirmed that they were unaware of the resident's sleep preferences and it was not identified in the written plan of care. [s. 26. (3) 21.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols are reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

Review of the written policies and interviews held with the DORS and pharmacist confirmed that the policies of the medication management system are reviewed by the DORS however, the approval of the policies are solely conducted by Medi-system. The DORS and Medical Director are not involved in the approval. [s. 114. (3) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review and interviews held with the administrator and the DORS confirmed that the medication management system is not evaluated on an annual basis. [s. 116. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home has received annual training in infection prevention and control.

Record review and interview with the DORS confirmed that seven percent of all staff did not receive
training in infection prevention and control. [s. 219. (1)]

Issued on this 13th day of February, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAN DANIEL-DODD (116), JOANNE ZAHUR (589), JOELLE TAILLEFER (211), SARAH KENNEDY (605)
Inspection No. / No de l'inspection :	2015_378116_0001
Log No. / Registre no:	T-032-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 12, 2015
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE GIBSON LONG TERM CARE CENTRE 1925 STEELES AVENUE EAST, NORTH YORK, ON, M2H-2H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SOILI HELPPI

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_189120_0055, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

The licensee shall ensure that staff has been screened for tuberculosis in accordance with evidence- based practices set out by the Canadian Tuberculosis Standards and the Toronto Department of Public Health and that a copy of the tuberculosis test results for staff are kept on file within the home.

The compliance plan is to be submitted on or before February 25, 2015 to: Saran.DanielDodd@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that staff was screened for tuberculosis in

accordance with evidence-based practices and, if there are none, in accordance with prevailing practices that are sustained in the home policy whereby, all new employees being hired must submit copies of the results of a two- step tuberculin skin test (TST).

The following non-compliance was issued on September 15, 2014, during inspection #2014_189120_0055, log #T-387-14 and remains outstanding.

The Canadian Tuberculosis Standards, 7th edition, Chapter 4: Diagnosis of Latent Tuberculosis Infection" dated February 2014, identifies that a two-step tuberculin skin test (TST) should be performed if subsequent TSTs will be conducted at regular intervals. This is to reduce the chance of a false-positive TST conversion when the TST is repeated. The two-step protocol needs to be performed once only if properly performed and documented. Any subsequent TST can be one step, regardless of how long it has been since the last TST.

Review of the current Toronto Public Health directive entitled "Recommendation for Tuberculosis (TB) Screening in long term care homes for employees and volunteers" updated February 14, 2013, indicates that an assessment for employees and volunteers with unknown TST must receive a two-step TST initiated within six months before starting work or within 14 days of starting work. A person needs to receive a one-step TST if the previous documented results of previous two-step TST was done over six months. A person does not need further testing if both previous two-step TST were negative and was done less than six months ago.

Review of the home's policy titled "Tuberculosis Screening for Staff" (# LTC-CA-WQ-205-05-05, revised in January 2015), documents that all new employees being hired must submit copies of the results of a two- step TST (Mantoux test) completed within the last six months.

Review of the Licensee Confirmation Checklist for Infection Prevention and Control signed by the director of resident services (DORS) indicated that staff are screened with "two-step" TB test (TST) and a follow-up chest x ray if the result is positive.

Record review of a new employee hired on an identified date, and interview with the administrator revealed that the employee submitted a copy of a one-step TB. Interview with the administrator confirmed that the home does not have any

supporting documentation to confirm that the new employee has received a two-step TST (Mantoux test) in the past to confirm TST result. [s. 229. (10) 5.]

(211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN Daniel-Dodd

Service Area Office /
Bureau régional de services : Toronto Service Area Office