Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2016	2016_389601_0004	004922-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

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

KARYN WOOD (601), CAROLINE TOMPKINS (166), DENISE BROWN (626), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 22, 23, 24, 25, 26, 29, and March 1, 2, 2016.

The following were inspected during the course of the Resident Quality Inspection:

A complaint regarding responsive behaviours, plan of care and the admission process.

A complaint regarding no orientation when staff are requested to work in different home areas.

Three critical incidents related to staff to resident alleged abuse/neglect.

A critical incident related to communication and response system not functioning properly.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator (CC), RAI Coordinator (RAI-C), Registered Nurses (RN), Registered Practical Nurses (RPN), Health Care Aides (HCA), Personal Support Workers (PSW), Social Worker, Housekeeping Workers, Maintenance Worker, Environmental Service Manager(ESM), Resident and Family Council President, Residents and Family members.

Also completed during the inspection, the Inspector(s), toured the resident home areas, observed staff to resident provision of care, dining service, infection control practices and medication administration. The Inspector(s) reviewed residents clinical health records, internal abuse investigations, staff education records, maintenance records, applicable policies, resident and family council minutes, admission process, complaints and critical incidents.

The following Inspection Protocols were used during this inspection:

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

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

- **10 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 3 (1) 11. iv, by ensuring that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act has been fully respected and promoted.

The following observation was made on February 26, 2016:

- During a medication administration observation, Registered Practical Nurse #117 was observed throwing the empty medication strip packages into a garbage bag, which was located on the side of the medication cart. The medication strip packages contained the first and last name of individual residents, date and times of medication administration, medication names, and dosage.

Registered Practical Nurse #117 and the Clinical Coordinator indicated that the garbage bag containing the empty medication strip packages are disposed of into general unit garbage, for pick up by housekeeping staff. RPN #117 indicated that historically registered nursing staff would place the empty medication strip packages into a container, pour water onto the strip packages to remove resident names and medications, and then dispose of them. RPN #117 indicated that this process is no longer in place and that empty medication strip packages are disposed of into the general home's garbage.

The Clinical Coordinator indicated that the process which historically included watering down of the strip packages to remove personal health information was found by registered nursing staff to be messy and hence the change in the practice of handling and disposal of empty medication strip packages.

The Clinical Coordinator indicated that resident names and medications would be considered personal health information, and acknowledged that there would be a potential for a person to access the garbage bags containing the empty medication strip packages and intern accessing personal health information. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential in accordance with that Act, fully respected and promoted by discarding medication strip packaging accordingly, 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. (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 failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care is provided to the resident as specified in the plan, specific to personal care and continence care management.

Related to log #024050-15, for Resident #044:

Resident #044 is cognitively well. Resident is dependent on staff for activities of daily living, due to physical / mobility impairment.

Resident #044 reported that Personal Support Worker (PSW #107) was rude while providing bedtime care, on an identified date. Resident #044 indicated PSW #107 refused to provide hygiene and continence care.

The plan of care, for resident #044, in place at the time of the incident directed the following:
- Personal hygiene: Resident requires extensive assistance of one to two staff. Staff to provide extensive assistance with hygiene, but resident can participate and do small parts by washing face and hands;
- Toileting: Resident requires extensive to total assistance for all aspects of toileting;
- Urinary Incontinence: Resident is at risk for alteration in skin integrity.

Personal Support Worker #111 indicated witnessing the care refusal and comments directed towards resident #044 by PSW #107. PSW #111 indicated not intervening.

Personal Support Worker #107 indicated being upset with comments made to resident #044 on the identified date and acknowledged not providing hygiene and continence care to resident #044.

There is no evidence to support that Resident #044 received personal care and or incontinence care on the evening identified.

Director of Care indicated that the expectation is that care is provided to residents as specified in the plan of care. [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 by ensuring the care set out in resident #044's plan of care is provided to the resident as specified in the plan, specific to personal care and continence care management, to be implemented voluntarily.

WN #3: 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 has failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during the dates of this inspection:

- Flooring – the one sheet, laminate flooring in six identified resident washrooms was observed to be pulling away from the floor and wall, leaving gaps where exposed sub-flooring was visible. It was further observed, that the laminate or tiled flooring in resident room and or adjoining washroom had cracked or missing tiles and or spilt seams in seven identified rooms. Areas where the sub-flooring was exposed had visible debris present.

- Transition (or threshold) piece - which separates the resident room and the adjoining

washroom flooring, was observed to be missing in nine identified resident rooms; the sub-flooring was exposed and visible debris was evident.

- Walls – were observed chipped, gouged and or missing paint, in ten identified resident rooms and adjoining washrooms.

- Wall-Guard- missing or loose in an identified resident room.

- Closet Door – scratched and gouged, with pieces of wooden veneer visibly peeling, in two identified resident rooms.

- Toilet Seat – was scratched along the seat surface, with visible dark substance between the ridges of the scratches, in an identified resident room.

The maintenance request log binders were reviewed for a two month period and failed to provide evidence to support that the maintenance repairs required above had been identified by staff of the home.

Maintenance Worker #116, who is the full-time maintenance personnel for the home, indicated:
- Not being aware of any flooring issues and missing transition pieces within the home.
- Resident room touch up's (which would include, wall damage, closet damage and or missing wall-guards) are repaired based on safety and priority; and that the priority is vacated rooms awaiting admissions.

The Maintenance Worker and the Support Services Manager both indicated that the maintenance department relies on staff (nursing and housekeeping) staff to communicate areas within the home needing repair. If staff do not, report maintenance issues using the maintenance request log, it is difficult for the maintenance department to make required repairs and or replacement of issues within the home.

Support Services Manager indicated having some knowledge of the flooring disrepair, within resident rooms and adjoining washroom, but indicated there currently are no plans in place for the flooring repairs in 2016.

Support Services Manager indicated the expectation is that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as identified in seventeen identified rooms, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Related to inspection log #025733-15

The licensee has failed to ensure the licensee's policy #OPER-02-02-04 that promotes zero tolerance of abuse and neglect which includes immediate verbal reporting to the Administrator, Director of Care or their designate of any suspected or witnessed abuse including improper or incompetent treatment of a resident was complied with.

Critical incident was received on an identified date alleging improper /incompetent treatment of resident #043.

The CI indicated eleven days prior to receiving the critical incident, RPN# 109 entered resident #043's room to administer medication. PSW #110 informed RPN #109, that resident #043 was only taking minimal sips of fluid.

RPN #109 allegedly pushed the spoon of pills into the resident's mouth and then began to pour apple juice into the resident's mouth.

On another identified date and time, PSW #110 went to provide care to resident #043 and found the resident appeared to be in distress.

PSW #110 approached RPN #109 to report and get assistance for the resident's condition. RPN #110 allegedly made a comment that concerned PSW #110 and then RPN #109 left the room without providing resident #043 with any comfort measures.

PSW #110 then called the RN for support and assistance. Resident #043 was immediately assessed by the RN and comfort care was provided to the resident by the RN and the PSWs attending the resident.

Documentation indicated the RN assessed the resident and did not find the resident experienced any physical or emotional stress due to the incident.

Ten days following the second incident, PSW #110 sent an email to the DOC that alleged concerns regarding the care provided by RPN #109. The DOC received the email twelve days following the first incident and immediately initiated the investigation.

Therefore, PSW #110 witnessed the alleged incidents of improper/incompetent care on two identified dates, but did not report those allegations to the Administrator, Director of Care or their designate immediately as required in the policy. (166)

Related to inspection log #024050-15:

The home's policy, Resident Abuse-Staff to Resident (#OPER-02-02-04) provides staff and administrative team direction for identifying, reporting, investigating and responding to suspected or witnessed abuse of a resident by a staff member. The policy acknowledges that Extendicare has a zero tolerance of abuse towards residents; indicating that all staff who have reasonable grounds to suspect that abuse or neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director and or governing provincial regulatory body.

The home's policy, Resident Abuse-Staff to Resident, directs that:

All Staff:
- if abuse is witnessed, separate resident from the alleged perpetrator, if safe to do so;
- stay at the scene and comfort the resident
- immediately report (verbally) any suspected or witnessed abuse, incompetent care or

treatment of a resident to the Administrator, Director of Care or their designate (e.g. supervisor) . The abuse and or neglect must be reported as required by provincial legislation; in Ontario, the Director (MOHLTC) must be notified by Critical Incident Report and after hours contact number.

Upon notification, of an allegation, suspected or witnessed abuse incident, the supervisor is to assess the resident, to ensure safety; and provide emotional support. An investigation is to be initiated by the supervisor, including initiating a preliminary report; the report is to be completed by the supervisor before going off duty.

The policy further directs that the substitute decision maker will be notified within twelve hours of an allegation, suspicion and or witnessed abuse and or neglect being reported.

The Director of Care submitted a critical incident on an identified date, for a witnessed incident of alleged staff to resident abuse.

Details of the incident are as follows:
- Resident #044 reported that Personal Support Worker (PSW #107) was rude while providing bedtime care. Resident #044 indicated PSW #107 refused to provide hygiene and continence care.

Personal Support Worker #111 and Registered Practical Nurse #108, failed to comply with the home's policy, Resident Abuse-Staff to Resident, as evidenced by the following:

Personal Support Worker #111:
- PSW #111 witnessed the incident between resident #044 and PSW #107. PSW #111 did not intervene, nor did PSW #111 report what was witnessed to Registered Practical Nurse #108 or the RN-Charge Nurse on duty.

Registered Practical Nurse #108:
- RPN #108 acknowledged receiving a verbal report from PSW #107, on the evening of the incident, in which PSW #107 reported not providing resident #044 personal and incontinence care. PSW #107 further reported to RPN #108 making inappropriate comments to the same resident (#044). RPN #107 failed to report the reported incident to RN-Charge Nurse, the Director of Care or the Administrator.
- Registered Practical Nurse #108 did not document details of the incident which occurred on the identified date, until asked to by the Director of Care two days post incident. There is no evidence to support that resident #044 was assessed or provided

with emotional support until three days following the incident.
- The substitute decision maker of resident #044 was not notified by RPN #108 of an incident involving staff to resident abuse two days after the incident occurred.

The home's policy, Resident Abuse-Staff to Resident, was not complied with as further evidenced by the following:

- The witnessed and reported staff to resident abuse incident was not immediately reported to the Director. The staff to resident abuse incident was not reported to the Director, until two days following the witnessed incident.

Administrator acknowledged that the home's policy that promotes zero tolerance of abuse and neglect of residents was not complied with. (554) [s. 20. (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 by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: 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), by not ensuring that residents have their personal items labelled within 48 hours of admission and when acquiring new items.

The home's policy, Continuum of Care (#RESI-04-02-02) directs that all personal care articles are to be appropriately marked, to prevent loss and or confusion.

The following was observed during dates of this inspection:

- In an identified room – two basins were observed lying on dresser outside of the washroom; both basins were unlabelled. This is a shared resident room.
- A toothbrush and a comb, were observed lying on the surface of the sink, behind the taps; both items were unlabelled. This is a shared resident washroom.
- In an identified room – two toothbrushes were observed lying on a steel shelving unit above the sink in the washroom; both items were unlabelled. This is a shared washroom, not only with room #318, but also adjoining resident room.
- In an identified room – two toothbrushes were observed lying on a steel shelving unit above the sink in the washroom; both items were unlabelled. This is a shared resident washroom.
- In an identified room – two toothbrushes and a bottle of lotion were observed lying on the counter-top in the washroom; all items were unlabelled. This is a shared resident washroom.
- In an identified room – two used disposable razors, a tube of toothpaste and a toothbrush were observed lying on the counter-top in the washroom; all items were unlabelled. This is a shared resident washroom.

Personal Support Worker #113, Registered Practical Nurse #112 and the Clinical Coordinator, all indicated that personal care items, such as toothbrushes, combs, and razors are to be labelled using a resident's name.

Clinical Coordinator indicated it is the responsibility of the night staff (personal support workers) to label personal care items, but the responsibility of all staff to identify items, which are not clearly labeled and bring this to the attention of registered nursing staff.

The Director of Care indicated that the expectation is that all resident personal care items are to be labelled on admission and as a resident receives new items for use. [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 by ensuring that the resident's identified have their personal items labelled within 48 hours of admission and when acquiring new items, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 76 (4), by not ensuring that all staff have receive retraining annually relating to the following:

• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

Staff Educator indicated that there was 193 staff working at the home in 2015.

Staff Educator indicated that 175 staff were provided annual re-training in 2015, specific to the Resident Bill of Rights, home's policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting and whistle-blowing protection. Staff Educator indicated that all staff were scheduled to attend re-training sessions in July and September 2015, and that according to re-training records, eighteen staff did not attend re-training sessions and were considered no-shows for sessions.

Staff Educator indicated there is no rationale for the eighteen staff not to have attended

the training sessions or to have completed their annual re-training.

2. Related to Intake #024050-15:

Personal Support Worker #111 witnessed an incident of staff to resident abuse / neglect which was said to have occurred on an identified date. This incident was not reported on the date to which it was said to have occurred.

Staff Educator indicated, that Personal Support Worker #111 did not receive annual re-training in 2015, Resident Bill of Rights, home's policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting and whistle-blowing protection. Staff Educator indicated that PSW #111 did not attend her scheduled re-training during September 2015.

Director of Care indicated not being aware that PSW #111 had not completed the required re-training in 2015.

Administrator and the Director of Care indicated it's an expectation that all staff complete the required annual re-training. Director of Care indicated not being aware that PSW #111 had not completed the required re-training in 2015. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that all staff receive retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections, to be implemented voluntarily.

WN #7: 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:
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. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (10) 1, by not ensuring that each resident admitted to the home has been 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.

The Clinical Coordinator, who is the lead for the home's Infection Prevention and Control Program, indicated that the long-term care home currently follows the Peterborough City and County Health Unit (PCCHU) guidelines for tuberculosis screening for new admissions being admitted to long-term care. Clinical Coordinator indicated that PCCHU guidelines are also the tuberculosis screening guidelines directed by PIDAC (Provincial Infectious Disease Advisory Committee).

The PIDAC guidelines for tuberculosis screening direct the following:

All new residents must undergo a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. It is recommended that this assessment include,
1. A symptom review for active pulmonary TB disease.
2. A chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility.
3. If signs and symptoms and/or chest x-ray indicate potential active pulmonary TB disease, the resident should not be admitted until three sputum samples taken at least one hour apart are submitted to the Public Health Lab for testing (Acid Fast Bacilli and Culture) and the results are negative. Note: It can take up to 8 weeks for a culture report.
4. In addition to the above, for residents less than 65 years of age who are previously skin test negative or unknown, a 2-step tuberculin skin test (TST) is recommended. If the TST is positive, treatment of latent TB infection (LTBI) should be considered. A TST is

not recommended for residents with a previous positive TST.

Tuberculin skin tests are not recommended to be done upon admission for residents 65 years of age or older.
Reference: Canadian Tuberculosis Standards, 7th edition, 2013

A memo, entitled immunization updates required, was posted on the wall within the Rose Terrace (resident home area) nursing station; the memo was dated February 24, 2016 and issued by the Clinical Coordinator, who is the lead for the home's Infection Prevention and Control Program. The memo indicated that six residents residing within the home required chest x-rays.

The clinical health records for the six residents identified, as needing chest x-rays, were reviewed. Five of the six resident's health records identified the following:

- Resident #050 was admitted to the long-term care home on an identified date. A review of the clinical health record (progress notes, medication administration records, immunization and screening records, diagnostic records, as well as the community care access centre package) failed to provide evidence that resident #050 was screened for tuberculosis. Resident #050 was admitted to the home 116 days ago.

- Resident #051 was admitted to the long-term care home on an identified date. A review of the clinical health record (progress notes, medication administration records, immunization and screening records, diagnostic records, as well as the community care access centre package) failed to provide evidence that resident #050 was screened for tuberculosis. Resident #051 was admitted to the home 233 days ago.

- Resident #053 was admitted to the long-term care home on an identified date. A review of the clinical health record (progress notes, medication administration records, immunization and screening records, diagnostic records, as well as the community care access centre package) failed to provide evidence that resident #053 was screened for tuberculosis. Resident #053 was admitted to the home 266 days ago.

- Resident #054 was admitted to the long-term care home on an identified date. A review of the clinical health record (progress notes, medication administration records, immunization and screening records, diagnostic records, as well as the community care access centre package) failed to provide evidence that resident #054 was screened for tuberculosis. Resident #054 was admitted to the home 224 days ago.

- Resident #055 was admitted to the long-term care home on an identified date. A review of the clinical health record (progress notes, medication administration records, immunization and screening records, diagnostic records as well as the community care access centre package) failed to provide evidence that resident #055 was screened for tuberculosis for a nine month period. On an identified date (279 days post admission), resident received the first step of the two-step Mantoux, results are indicated in the clinical health record as the initial screening to be negative. At the time of this inspection, resident #055 has not been provided the second step of the two-step Mantoux. Resident #055 was admitted to the home 305 days ago.

Clinical Coordinator indicated that Registered Nursing Staff are to screen all residents admitted to the home for tuberculosis within fourteen days of admission and to record results in the clinical health records under immunization and screening records. Clinical Coordinator indicated knowing that five residents residing in the home had not been screened for tuberculosis on admission, and indicated that registered nursing staff had been reminded on three separate occasions and despite reminders, that the screening hasn't been completed, hence the reason for the posted memo.

Director of Care indicated no knowledge of the tuberculosis screening being deficient for five residents residing within the home. The Director of Care indicated that it would be an expectation that residents admitted to the home would be screened for tuberculosis. [s. 229. (10) 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 by ensuring that each resident admitted to the home has been screened for tuberculosis within 14 days of admission, specifically resident #'s 050, 051, 053, 054, and 055, 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 be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

Related to inspection log #012363-15:

1. The licensee failed to ensure the 24-hour admission care plan identified any risk that resident #046 may have posed to others, including any potential behavioural triggers and safety measures to mitigate that risk.

Resident #046 was transferred to the hospital due to an episode of increased responsive behaviours.

On an identified date a complaint was received from resident #046’s family member indicating that the home did not manage the resident’s behaviours properly.

During an interview, resident #046’s family member indicated that staff did not understand how to approach resident #046 and that more education was required.

Review of resident #046’s 24 hour admission care plan indicated that responsive behaviours had not been identified and there were no interventions in place for responsive behaviours.

Review of the progress notes over a four day period identified that resident #046 was refusing medication and that resident #046’s family member had indicated to staff that resident #046 becomes agitated if woken up. On the following day resident #046 raised a hand towards another resident. On the next day resident #046's was wandering into other residents rooms and was difficult to redirect. Resident #046 also refused medication and was throwing items into the hallway.

Review of progress notes on an identified date resident #046 was found sleeping in another resident’s room. PSW #129 approached the resident and attempted to redirect resident #046 back to resident #046's room. Resident #046 became angry and barricaded self in the bathroom.

Resident #046’s responsive behaviours continued to escalate and the police were notified and the resident was transferred to the hospital on an identified date.

Therefore, the 24 hour admission care plan did not include any potential behavioural triggers, and interventions to mitigate the responsive behaviours and staff did not have clear direction on how to manage resident #046's responsive behaviours. [s. 24. (2) 2.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of Resident Council minutes over a three month period, indicated resident #056 and #057 brought forward concerns related to the possibility of re-staining some furniture in resident's room and putting cabinets in resident's bathroom and that there had been no response from the licensee related to those concerns.

During an interview, the ESM indicated not being aware of the concerns brought forward during the Resident Council meetings on the three identified dates related to the re-staining of furniture and bathroom cabinets.

During an interview with the Assistant to the Resident's Council indicated that the Resident Council minutes which contained the discussion and the waiting of a response related to the re-staining of the furniture had been forwarded to all department managers following each meeting.

Interview with resident #056 and resident #057 indicated there has been no response by the licensee related to the question of the possibility of re-staining some furniture in resident's room and putting cabinets in residents' bathrooms . [s. 57. (2)]

WN #10: 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 failed to comply with O. Reg. 79/10, s. 87 (2) (d), by not ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The following observations were made during dates of this inspection:

- In an identified room, adjoining with another identified room – the shared washroom was identified on February 24, 2016 (at approximately 09:00 and 12:30 hours), as well as February 25, 2016 (at approximately 09:00 and 12:30 hours) to have a strong and lingering malodour, the smell resembled a urine-like odour.

-In an identified room– the shared washroom was identified on February 23, 2016 (at approximately 09:00 and 12:00 hours), as well as February 24 and February 25, 2016 (at approximately 09:00, and 12:30 hours) to have a strong and lingering malodour, the smell resembled a urine-like odour. A used catheter bag with attached tubing was observed hanging from a towel bar in this washroom.

HSK Aide #115, as well as the Support Services Manager indicated that resident washrooms are cleaned daily using a disinfectant floor cleanser. HSK Aide #115 indicated that daily cleaning of resident rooms and washrooms is the only measure currently in place to control odours within the home; HSK Aide indicated knowing of no formal policy or procedure in place for addressing lingering offensive odours. HSK Aide #115, who is the full-time housekeeper on the third floor, indicated being unaware of any lingering, offensive odours within resident washrooms.

Support Services Manager was not aware of the lingering, offensive odours in three identified resident washrooms #303/305. [s. 87. (2) (d)]

Issued on this 4th day of March, 2016

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

Original report signed by the inspector.