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
Nov 5, 2015	2015_393606_0011	T-1670-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

GEORGIAN MANOR HOME FOR THE AGED
7 HARRIET STREET PENETANGUISHENE ON L9M 1K8

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

JANET GROUX (606), NITAL SHETH (500), THERESA BERDOE-YOUNG (596)

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): July 28, 29, 30, 31, August 4, 5, 6, 7, 10, 11, 12, 2015.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator (A), Acting Director of Care (A)DOC, Environmental Services Manager (ESM), Food Service Manager (FSM), Food Service Supervisor (FSS), Registered Dietician (RD), Resident Assessment Instrument Coordinator (RAIC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Dietary Aide (DA),Housekeeping Staff, Maintenance, Facilities Manager, Supervisor of Programs and Support Services, Residents, and Families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **4 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. 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).

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

Findings/Faits saillants :

1. 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.

A review of a Critical Incident (CI) Report dated in May 2015, indicated resident #15 was found in an identified common area of the home inappropriately touching resident #1.

A review of resident #15's plan of care indicated the resident was found inappropriarely touching resident #1. Thirty minute checks and a Dementia Observation System (DOS) charting was started. Twenty minutes after this incident, resident #15 was found inappropriately touching resident #1. The plan of care revised indicated staff should attempt to avoid having resident #15 sit close to co-resident in common areas due to inappropriate behaviours.

A review of the progress notes indicated in June 2015, resident #15 touched resident #1 inappropriately.

Interview with PSW #129 confirmed that in June 2015, when the incident occurred, resident #15 was sitting beside resident #1.

Interview with RPN #103 and acting Director of Care (A)DOC #119 confirmed that the care set out in the plan of care was not provided to resident #15 and the incident was repeated in June 2015. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Record review of the progress notes and assessments for resident #13 revealed in January 2015, the resident developed altered skin integrity to identified areas and progressively worsened.

Record review of resident #13's written plan of care directed staff to turn and reposition the resident every two hours.

Interview with PSW #143 and RPN #144 revealed that staff are turning and repositioning resident every two hours and documenting.

Review of task assignment for resident #13 in the resident's clinical records revealed that turning and repositioning records for every two hours was not assigned to PSWs and there was no documentation to reflect resident #13's turning and repositioning as reported by the PSWs.

Interview with the RAI Coordinator confirmed that there were no electronic or manual records for turning and repositioning available for resident #13. [s. 6. (9)]

3. The licensee has failed to ensure that the following are documented: the provision of the care set out in the plan of care.

A review of resident #15's plan of care indicated the resident having inappropriate behaviours and attempting to touch other residents. DOS Q30 minute checks were initiated for the resident in May 2015, and discontinued in June 2015.

A review of the resident's Q30 minutes checklist revealed missing entries in June 2015. Resident did not have altered behaviours during these times.

Interview with RPN #123 and (A)DOC #119 confirmed staff did not document the above mentioned missing entries of Q30 minutes check. [s. 6. (9) 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:
-the care set out in the plan of care is provided to the resident as specified in the plan,
-the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director:

Review of resident #15's clinical records indicated that the resident was found inappropriately touching #1 in May 2015. In response to this incident, the home implemented 30 minute checks and DOS charting. Twenty minutes after this incident, resident #15 was found inappropriately touching resident #1. One to one monitoring was started for resident #15. In June 2015, resident #15 reached over and inappropriately touched resident #1.

Interview with PSW #124, confirmed two incidents that occurred between resident #1 and #15 in May 2015.

Interview with PSW #129 confirmed that while he/she was assigned one to one monitoring for resident #15 in June 2015, resident #15 sat beside resident #1 in an identified home area and inappropriately touched resident #1.

A review of a Critical Incident (CI) Report indicated that in May 2015, resident #15 was found in an identified area of the home and inappropriately touched resident #1. The CI report did not include any description of the other two incidents that occurred between resident #1 and #15 as mentioned above.

Interview with (A) DOC #119 confirmed he/she did not amend the above mentioned CI report for two other incidents that occurred between resident #1 and #15. The home did not inform the director about the two other incidents that occurred between resident #1 and #15 until August 2015. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of a CI Report regarding an alleged abuse incident during care identifying PSW #136 also revealed another incident that PSW #136 transferred resident #17 using a mechanical lift by his/herself.

A review of resident #17's plan of care revealed that resident requires two staff for transfers when using a mechanical lift.

Interview with PSW #136 revealed that he/she had transferred the resident by his/herself with the mechanical lift and confirmed that it was unsafe to do so.

Interview with the (A)DOC confirmed that two staff are required to operate a mechanical lift when transferring a resident. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

Review of the Family Council meeting minutes dated March, April, and May 2015, revealed that concerns were brought forward to the home related to infection control practices such as hand washing and masking practices of staff.

Record review of the home's written responses to the above mentioned concerns were not available as required in paragraph 8 of the LTCHA.

Interview with the acting Administrator confirmed that the home did not provide a written response for the above mentioned concerns to the Family Council within 10 days. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #5: 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be protected from abuse.

A review of a CI Report dated in May 2015, resident #15 was found in an identified area of the home and inappropriately touching resident #1.

Review of resident #15's clinical records indicated that the resident inappropriately touched resident #1 in May 2015. In response to this incident, the home implemented 30 minute checks and DOS charting. Twenty minutes after this incident, resident #15 inappropriately touched resident #1. One to one monitoring was started for resident #15. In June 2015, resident #15 reached over towards co-resident #1 and inappropriately touched resident #1.

Interview with PSW #124, who witnessed the first incident in May 2015, confirmed that resident #15 had inappropriate behaviours and was inappropriate towards resident #1.

Interview with PSW #129 confirmed that he/she was assigned one to one monitoring to resident #15 in June 2015, and was a few feet away from the resident. Resident #15 sat beside resident #1 in an indentified area of the home and inappropriately touched resident #1. PSW #129 confirmed that resident #15's behaviour was inappropriate towards resident #1.

Interview with RPN #123 and (A)DOC #119 confirmed that resident #1 should have been protected from resident #15's inappropriate behaviour. [s. 3. (1) 2.]

WN #6: 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).

s. 8. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has complied with the policy on monitoring resident's weight and height.

A review of the home's policy entitled "Monitoring Resident's Weight and Height", indicated each resident's height and weight will be taken on admission. Height will be measured annually with weight monitored monthly.

A review of resident #6 and #13's plan of care revealed their weights were not measured in July 2014.

A review of resident #9, #12, #13, #14, #18, #20, and #21's plan of care revealed their heights were not measured in 2014.

Interview with RPN #126, FSM #104, and Registered Dietitian (RD) #132 confirmed that the above mentioned residents weights and heights should have been measured. [s. 8. (1) (b)]

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

In July 2015, in the first floor dining room, the inspector observed resident #1 was served

orange juice and cranberry juice in plastic bowls. PSW #100 was observed to add two teaspoons of thickener to the resident's cranberry juice and stirred it to prepare it at honey consistency. The inspector did not observe PSW #100 following any recipe or a chart to thicken the cranberry juice.

A review of the document entitled "Resource Thicken Up" (manufacture's direction) indicated that to make one serving of cranberry juice at honey thick consistency, one table spoon and one teaspoon of thickener is required per six ounces of cranberry juice.

A review of the home's policy entitled "Thickened Fluids", indicated that staff are responsible for thickening fluids; follow manufacturer's preparation guidelines for amount of thickener to add to fluids for desired thickness."

Interview with PSW #100 confirmed that he/she did not follow the recipe/chart for thickened fluids because he/she did not have a recipe in the dining room. He/she was required to either follow the recipe to thicken the cranberry juice or return it to the dietary aide to make it at honey thick consistency.

Interview with RPN #103 confirmed that PSW #100 should have followed the recipe to make cranberry juice at honey thick consistency.

Interview with the food service supervisor (FSS) #105 and the food service manager (FSM) #104 confirmed that PSW #101 should have followed the recipe for thickened fluids. [s. 8. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home.

Record review of resident #8 Minimum Data Set (MDS) assessment conducted in June 2015 revealed that resident developed an area of altered skin integrity.

Review of resident #8's clinical records revealed that there was no assessment completed by the RD for the above mentioned.

Interview with the RD confirmed that she/he did not assess resident #8's nutritional status because he/she did not receive a referral.

Interview with Skin Care Consultant (SSC) #142 and the (A)DOC confirmed that registered staff should have sent a referral to the RD to assess the nutritional status to promote skin integrity. [s. 50. (2) (b) (iii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, residents are provided with a range of continence care products that are based on their individual assessed needs.

Review of resident #8's plan of care revealed that resident required an identified incontinent product for continence care. There was no assessment completed for the resident requiring this incontinent product.

Interview with PSW #127, and RPN #121 confirmed that resident #8 wears the identified incontinent product. RPN #121 confirmed that usually the service provider's representatives on the unit completes incontinent product assessment for residents however he/she could not find the assessment for incontinent product for resident #8.

Interview with (A)DOC #119 confirmed that the home could not find any assessment completed for resident #8 for incontinent product and asked the staff to initiate a new assessment. [s. 51. (2) (h) (i)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each snack.

On August 6, 2015, at 2:15 p.m., in an identified diningroom, the inspector observed PSW #101 serving snacks to residents. There were strawberry turnover cookies provided on the snack cart for residents having minced texture.

Interview with PSW #101 confirmed strawberry turn over cookies are soft and are provided for residents having minced texture.

Review of a week two Wednesday snack menu indicated apple turnover cookies were planned for pm snack for residents.

Interview with FSM #104 and RD #132 confirmed that staff should have provided apple turnover cookies for residents having minced texture for pm snack as indicated on the menu. [s. 71. (4)]

WN #10: 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 has failed to 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.

Record review of the home's annual training records revealed 18% of staff did not receive the training on the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reporting under section 24 and the whistle-blowing protections in 2014.

Interview with the (A)DOC confirmed that the above percentage of staff did not receive the above mentioned training in 2014. [s. 76. (4)]

WN #11: 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 inspection reports from the past two years for the long term care home are posted.

Observation on July 28, 2015, during the initial tour and record review, revealed two identified inspection reports were not posted.
The above observation was confirmed by the (A)Administrator. [s. 79. (3) (k)]

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. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment.

A review of the home's training records indicated 10% of staff did not receive training in Infection Prevention and Control (IPAC) in 2014.

Interview with (A)DOC #119 confirmed that the above percentage of direct care staff did not receive training in IPAC in 2014. [s. 219. (4)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provide direct care to residents: continence care and bowel management.

A review of the home's Continence Care and Bowel Management training records indicated 31.1% of direct care staff did not receive training in 2014.

Interview with (A)DOC #119 confirmed that the above percentage of direct care staff did not receive training in Continence Care and Bowel Management in 2014. [s. 221. (1) 3.]

2. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training is provided to all staff who provide direct care to residents: mental health issues, including caring for persons with dementia and behaviour management.

A review of the home's training record indicated 31.1% of direct care staff did not receive training in mental health issues, including caring for persons with dementia and behaviour management in 2014.

Interview with the (A)DOC #119 confirmed that the above percentage of direct care staff did not receive training in mental health issues, including caring for persons with dementia and behaviour management in 2014. [s. 221. (2)]

WN #14: 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 has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) Program.

In July 2015, in an identified dining room, the inspector observed that PSW #101 did not

perform hand hygiene on three occasions after clearing soiled bowls and juice cups. He/she was observed clearing bowls on the dirty utility cart and without performing hand hygiene, touched the servery counter, received order for residents and served the main course to residents.

Interview with PSW #101 confirmed he/she was required to perform hand hygiene after clearing soiled bowls and cups and before moving to another task.

Interview with RPN #103 confirmed that PSW #101 should have performed hand hygiene after clearing soiled bowls and cups and before moving to another tasks.

-In July 2015, in an identified dining room, the inspector observed dietary aide #102, serving dessert and beverages to residents using a cart. On one occasion, he/she was observed holding a soiled plate in his/her hand to clear it out on the dirty utility cart. Before he/she cleared it, PSW #101 took the soiled plate from him/her and cleared it. Dietary Aide #102 without performing hand hygiene continued touch the dessert cart and served desserts and beverages to residents.

Interview with RPN #103, FSS #105 and FSM #104 confirmed that the Dietary Aide #102 should have performed hand hygiene after giving the soiled plate to PSW #101.

-In July 2015, in an identified dining room, the inspector observed PSW #100 wipe resident #1's mouth with wipes, and removed his/her clothing protector. Without performing hand hygiene PSW #100 pushed resident #1's wheelchair to transfer him/her from the dining room. Then PSW #100 stopped and encouraged resident #3 to drink his/her beverage by providing him/her a cup of beverage into his/her hands.

Interview with PSW #100 confirmed that he/she should have performed hand hygiene after removing a clothing protector from resident #1 and before encouraging resident #3 to finish his/her beverage.

Interview with RPN #103, FSS #105, and FSM #104 confirmed that PSW #100 should have performed hand hygiene prior to wiping resident #1's mouth and removing clothing protector and before providing resident #3 a cup of beverage.

Interview with RD #132 and (A)DOC and IPAC lead #119 confirmed staff should have performed hand hygiene in between the tasks in the dining room. [s. 229. (4)]

2. During the initial tour in July 2015, the inspector observed the following:
- Three unlabelled toenail clippers stored in a drawer near the sink of an identified unit's shower room.

Interview with RN #106 revealed that the toenail clippers should not be stored in the drawer, and should be stored in residents' respective labelled small drawer for nail and toenail clippers.

- one unlabelled toenail clipper and one nail clipper in a drawer near the sink of a tub room, and one used deodorant and unlabelled hairbrush in the shower room drawer near the sink on an identified floor and unit.

Interview with PSW #107 revealed that the toenail and nail clippers should not be stored in the drawer, and should be stored in residents' respective labelled small drawer for nail and toenail clippers. PSW #107 reported that he/she did not know who the used deodorant and hairbrush belonged to, and that residents' personal belongings should be stored in residents' rooms.

- one unlabelled comb and brush in drawer near sink in tub room on an identified unit.

Interview with PSW #108 confirmed that the above mentioned residents' personal items should not be stored in the tub room, they should be stored in the respective resident's room. [s. 229. (4)]

Issued on this 29th day of November, 2015

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

Original report signed by the inspector.