Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 9, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, Apr 2, 3, 4, 10, 16, 17, 2012	2012_109153_0008	Resident Quality Inspection

Licensee/Titulaire de permis

CLURELEA LTD.
272 QUEEN STREET EAST, BRAMPTON, ON, L6V-1B9

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

GOOD SAMARITAN NURSING HOME
481 Victoria Street East, Alliston, ON, L9R-1J8

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

LYNN PARSONS (153), CATHERINE PALMER (152), GLORIA STILL (164), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care,Manager of Food Services, Activity Director, Environmental Services Supervisor, Physiotherapist, Registered Nurses,Registered Practical Nurses, Personal Support Workers, Physio Aide, Housekeeper, Laundry Aide, Residents and Families.

During the course of the inspection, the inspector(s) Reviewed resident health care records, policies and procedures, staff in-service attendance records, resident satisfaction survey results, Resident Council minutes, Family Council minutes, pet vaccination records and advisory committee minutes.
Observed provision of care and staff interactions

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff collaborate with each other in the development and implementation of the plan of care for the identified resident so that different aspects of care are integrated and are consistent with and complement each other
Interview with physiotherapist revealed that he recommended that the identified resident wear a hand posey on right hand at all times, day and night. Resident's written plan of care and interviews with identified resident's caregivers revealed that the resident uses a hand posey in right hand all day, to be removed at night. [s.6(4)(b)]
2. An identified resident's plan of care does not provide clear direction to staff providing care to the resident. Plan of care for bed mobility indicates the resident requires staff for all bed mobility due to inability to move self, compromised skin integrity and falls. Staff interviews confirmed the resident can move in bed on own and requires 2 side rails in bed to prevent falls and to reposition self. [s.6(1)(c)]
3. The written plan of care does not set out clear directions for the staff and others who provide direct care to the resident. The plan of care for the identified resident provides conflicting information related to oral care. The care plan directs staff to complete the following oral care:
"Daily cleaning of teeth or dentures, or daily mouth care by client or staff"
"Encourage resident to clean own teeth and denture Qam and Qpm"
"Remove and rinse dentures after each meal"
"Soak dentures Qpm, rinse Qam"
Resident and staff indicated during interviews that resident doesn't wear the upper denture because it is uncomfortable. Staff confirm resident has not worn upper denture for several years.
Interviews with various PSWs and the resident indicated staff provide oral care in different ways. ie. some use a toothbrush and others use mouth swabs to complete resident's oral care.
Some staff set up resident and others complete the oral care themselves.
Resident prefers to brush own teeth and not use the mouth swabs.[s.6(1)(c)]
4. The care set out in the plan of care was not provided as specified in the plan.
The written plan of care for the identified resident indicates the resident is to be positioned in proper body alignment including extremities that are affected by neuro-muscular or musculo-skeletal impairment and is to sit in an upright position for meals. The resident was observed in the dining room on March 16, 2012 at 12:25 hours sitting in the wheel chair with head tilted to the right, was repositioned and again head tilted to the right. On March 20, 21, 22, 23, 2012 the resident was observed tilted in wheel chair during meals. A PSW reported the resident is tilted in the wheelchair during meal service because the resident leans forward. The registered staff reported the resident is to be fed in an upright position.[s.6(7)]
5. Care was not provided to the identified as specified in the written plan of care.The written plan of care for the identified resident under the section for falls directs staff to "ensure call bell within reach at all times".
During observations completed on March 16, 2012 @ 09:10, 09:50 and 11:30 hours it was noted that the resident was sitting in resident room in the wheel chair watching TV, 1 Call bell cord lying across the top of the bed and 1 call bell cord lying on floor at the side of bed. Call bells were not accessible to resident while the resident was watching TV. Through interviews with staff it was confirmed the call bells must be accessible at all times because the resident will attempt to toilet self without the assistance of staff. [s.6(7)]
6. The plan of care was not revised when the resident's care needs change. The written plan of care for the identified resident who is MRSA positive was not revised to include infection prevention and control measures required during the provision of care. [s.6(10)]
7. Care was not provided to the identified resident as specified in the plan of care. On March 9, 2012, 15:45 hours, a PSW was observed transporting the identified resident in a sit/stand lift from the bathroom in resident room. The PSW was not assisted or accompanied by another staff member as required by the resident's plan of care.
Instruction sheet on resident's cork board also indicates that resident is to be transferred using a sit/stand lift and 2 assistants.[s.6(7)]
8. Plan of Care for the identified resident does not provide clear directions to staff and others who provide direct care to the resident. The resident's plan of care for transferring indicates both that the resident is lifted mechanically and manually. The plan of care does not include specific details to indicate which transfer method should be used and when. [s.6(1)(c)]
9. The care set out in the plan of care was not provided as specified in the plan. On March 15, 2012 at 14:55 hours the identifiedresident was observed in bed with sheepskin boots on both feet. PSW staff reported the resident's sheepskin boots are to be removed when in bed.
The written plan of care includes sheepskin booties to both feet when up & off when in bed. [s.6(7)]

10. The written plan of care for a resident with an identified risk for falls fails to provide clear directions related to transfer requirements.
The plan of care provides conflicting information as it relates to the number of staff and the use of transfer equipment when resident is transferred from bed to chair and chair to bed.
The plan of care states, "resident needs one to two staff to transfer due to faulty weight bearing","uses one staff and pole for transfers into the wheel chair in room due to leg weakness from brain injury".
Interviews with staff and resident confirmed resident is transferred with 1 staff member with the use of a transfer pole at the bedside.[s.6(1)(c)]
11. The care set out in the plan of care is not provided to the resident as specified in the plan.
The identified resident's written plan of care and staff interviews confirmed that the resident requires supervision when ambulating. On March 16, 2012 the resident was observed ambulating without supervision in the hallway. [s.6(7)]
12. The care set out in the plan of care is not provided to the resident as specified in the plan.
The identified resident's plan of care states that resident is to wear a hand posey in right hand, for contractures. On March 20, 2012 the resident was observed in the dining room without the hand posey in place. Staff explained that the hand posey had been sent to the laundry that day, so it was not available for the resident's use at that time.[s.6(7)]
13. The plan of care for the identified resident does not provide clear direction to staff related to bed mobility. The written plan of care for the indicates the resident requires total assistance for bed mobility and transfers; uses bed rails for mobility or transfer; is a medium risk for falls; has 2 side rails up when in bed. PSW staff reported the resident cannot turn on own in bed and will hang on to the side rail when turned. The registered staff reported the resident has minimal ability to move in bed but requires side rails to prevent him from falling.

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 written plan of care for each resident includes:
- clear directions to staff and others who provide direct care to the resident
- that staff and others involved in the different aspects of care of the resident collaborate in the development and implementation of the plan of care so the different aspects of care are integrated and consistent with and complement each other
- the care set out in the plan of care is provided to the resident as specified in the plan
- that the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. During resident interview, the identified resident reported to the inspector that a staff member had told the resident to "stop crying like a baby and that it would be soon time for a bottle". Resident's daughter confirmed that the resident had informed her of the alleged verbal incident.[s.3(1)(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 all residents are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: 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 subsections:

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. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with. The home's policy for Resident Abuse and Neglect revised Oct 2010, states that employees will be provided with education on the prevention of elder abuse in long term facilities annually.
The home's policy for Staff Reporting and Whistle Blowing Protection of February 2011, states that employees will receive annual re-training on the reporting obligations under the LTCHA, the home's internal procedures for reporting, and the whistle-blowing protections in the LTCHA. Less than half of the home staff received this training in 2011 as confirmed by review of the home's training records and interview with the Administrator on March 23, 2012.

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's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that home's policy Minimizing Restraining of Residents: Use of restraints of February 2012 was complied with. The Registered staff reported that on February 9, 2012,an identified resident was restrained in a wheel chair with a seat belt restraint for the resident's safety while being fed lunch. Registered staff reported that this was an immediate, short term intervention, to prevent serious bodily harm. The restraint was removed following the meal. The policy was not complied with related to the use of a restraint in an emergency situation as a verbal order was not obtained from the physician within 12 hours. There is no documentation indicating the time of restraint application and the resident's reactions. [s.29(1)(b)]
2. The licensee failed to ensure that the home's policy Minimizing Restraining of Residents: Use of restraints of February 2012 is complied with related to the use of two bed rails, for the identified residents when in bed. The home's policy defines an environmental restraint as any device or barrier that limits the movements of an individual, and thereby confines an individual to a specific geographic area or location. The plans of care for the three identified residents indicates 2 bed rails up when in bed to prevent falls. Staff interviews confirmed the use of side rails to prevent falls. The procedure outlined in the policy has not been implemented as the home's staff do not consider the use of bed rails to be a restraint. [s.29(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 the home's policy Minimizing Restraining of Residents: Use of restraints of February 2012 is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who are being restrained by a physical device have a restraint plan of care in place.
There is no restraint plan of care for the identified residents as the licensee does not consider the use of side rails used for these residents as a restraint.
The plans of care for the three identified residents indicates 2 bed rails up when in bed to prevent falls. Staff interviews confirmed the use of side rails to prevent falls.

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 residents who are being restrained by a physical device have a restraint plan of care in place, 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 subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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 not ensured that all staff who provide direct care to residents have received annual retraining related to abuse recognition and prevention as required in the regulations.
2. The licensee failed to ensure that a registered staff member hired in October 2011 has received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing the job responsibilities. The administrator, was unable to provide documentation to support that the staff member received the training.
3. The licensee failed to ensure that all staff have received training on mandatory reporting under Section 24 of the Act before performing their duties, as confirmed through a review of training records and interviews with staff and administrator.

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 training and re-training is provided as required related to abuse recognition and prevention, the home's policy to promote zero tolerance of abuse and neglect, and the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

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's policy to promote zero tolerance of abuse and neglect of residents meets the requirements as set out in the LTCHA and Regulations, to be implemented voluntarily.

WN #8: 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 failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
On March 9, 2012, 1545 hours, a PSW was observed transporting an identified resident in a sit/stand lift out of the bathroom. The PSW was not assisted or accompanied by another staff member as required by the home's policy and the resident's plan of care. The PSW confirmed knowledge of the home's policy and indicated that no one was available to assist with the transfer until 1600 hours.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 36. Common law duty

Findings/Faits saillants :

If a resident is being restrained by a physical device pursuant to the common law duty described in section (1), the licensee shall ensure that the device is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36(2)
1. Following the application of a physical device pursuant to the common law duty referred to in section 36 of the Act, the licensee shall explain to the resident, or the resident's substitute decision-maker where the resident is incapable, the reason for the use of the physical restrain device. O.Reg. 79/10, s.110(4).

Pursuant to 110(4)the licensee failed to ensure that an identified resident's substitute decision maker was informed of the reason for the use of a physical device under common law duty as stated in O Reg 79/10 s. 110 (4).
The Registered staff reported that on February 9, 2012, an identified resident was restrained in a wheelchair with a seat belt restraint for the resident's safety while being fed lunch. Registered staff reported that this was an immediate, short term intervention, to prevent serious bodily harm.

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

Specifically failed to comply with the following subsections:

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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program. Staff failed to utilize measures to prevent the transmission of infections.
On March 9 and 16, 2012, having completed care to MRSA resident,a PSW was observed to exit resident rooms wearing PPE (personal protective equipment), yellow isolation gown. The PSW removed and discarded the isolation gown in the soiled linen hamper located down the hallway. The home's policy requires staff remove PPE prior to exiting a resident's room. The staff member confirmed the residents who had been provided care to were MRSA positive.

On March 12, 2012, at 0945 hours, a PSW was observed to be wearing gloves exiting the south wing shower room. The PSW re-entered the shower room and gathered wet towels from the floor, closed the shower room door, deposited the towels in a hamper, proceeded to the nurses station on south wing, obtained a key, walked to tub room, and unlocked the door, while still wearing the same gloves.

On March 14, 2012 at 1725 hours a Registered staff member was observed to administer insulin to 2 residents and then proceeded to complete a medication pass without sanitizing her hands between residents.

On March 15, 2012, 0750 hours a Registered staff member administered to the same resident insulin, eye drops and used her fingers to remove oral medications from the medication cup and placed them into the resident's hand. No hand hygiene was observed during this entire process.

On March 19, 2012, two lift slings soiled with feces were observed to be stored on the mechanical lift in the north shower room.
2. The licensee failed to ensure that screening measures for tuberculosis were in place within 14 days of admission for the identified residents.

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:
- all staff participate in the implementation of the infection control program
- all residents are 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 the screening are available to the licensee, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that the response and effectiveness of the identified resident's PRN tylenol was documented on February 16, March 15,16,18, 23, 2012. [s.134(a)]

WN #12: 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 subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(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;
(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;
(h) the name and telephone number of the licensee;
(i) an explanation of the measures to be taken in case of fire;
(j) an explanation of evacuation procedures;
(k) copies of the inspection reports from the past two years for the long-term care home;
(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;
(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;
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
(p) an explanation of the protections afforded under section 26; and
(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to comply with the requirement that the evacuation procedures are posted and communicated in the home.
2. The licensee has not ensured that the name and telephone number of the licensee are posted and communicated in the home.
3. The licensee has failed to ensure that the long term care home's procedure for initiating complaints within the home is posted and communicated in the home.
4. The licensee failed to ensure that an explanation of the protections afforded under section 26 were posted in the home. Upon notification of the requirement, the administrator posted the required information.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Findings/Faits saillants :

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,
a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
b) is complied with. O. Reg. 79/10 s.8(1)
1. The licensee failed to ensure that the policy titled Staff Reporting and Whistle Blowing Protection is in compliance with and implemented in accordance with all applicable requirements under the Act. The mandatory reporting under section 24 of the Act applies to all persons. According to O Reg 79/10 s. 105, paragraph 4 of subsection 24(5) of the Act exempts certain persons from being guilty of an offense for failure to report.
The home's policy outlines staff who are exempt from mandatory reporting(Appendix A). This is not in compliance with the LTCHA because mandatory reporting under section 24 of the Act applies to all persons. O. Reg 79/10 s. 105 paragraph 4 of subsection 24(5) of the Act exempts certain persons from being guilty of an offense.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident's 5 percent weight loss was assessed upon return from hospital in February 2012 using an interdisciplinary approach, and that actions were taken and outcomes evaluated. The dietitian was not notified of the identified resident's significant weight loss and did not assess the resident related to weight loss. [s.69(1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of the investigation undertaken with respect to a mandatory report under section 23 (1) of the Act. [s.23(2)]

WN #16: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report the suspicion of an incident under section 24(1)1 of the Act and the information upon which it was based to the Director.

WN #17: 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and a good state of repair.
The base of the vanity in the north shower room was observed to be damaged on March 20, 2012 at 08:05 hours. The environmental services supervisor confirmed that the area requiring repair was the result of water damage.
2. The licensee failed to ensure that the home, furnishings, and equipment are kept clean and sanitary.
The following observations were made on March 20, 2012 at 14:30 hours in the north shower room: stained privacy curtain, soiled ceiling fan above toilet, soiled wall vent. A soiled bath stretcher lift was noted in the north tub room.
The Housekeeping Audit was reviewed and it was noted that the shower room is not included on the audit form. There is a section for the tub room on the audit form.
On March 23, 2012 inspector observed the above areas and noted that all identified issues were corrected.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following subsections:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3);
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The results of the satisfaction survey are documented but according to residents have not been made available or discussed at Residents' Council.
2. The licensee failed to ensure that the results of the survey are made available to the Residents' Council to seek their advice under subsection (3). This information was confirmed through interviews with residents and the administrator.
3. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the survey, and in acting on its results as confirmed through interviews with residents and the administrator. A review of the Residents' Council minutes confirmed the same.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the seven day menu was communicated to residents. 6/9 residents surveyed confirmed that they were not aware of the home's seven day menu and were unaware of how to obtain the information. The seven day menu was not communicated to residents, other than those who are members of the food committee.

Issued on this 4th day of May, 2012

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

Lynn Parsons