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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2014	2014_188168_0005	H-000199-14	Resident Quality Inspection

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1

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

LISA VINK (168), ASHA SEHGAL (159), CATHIE ROBITAILLE (536), CYNTHIA DITOMASSO (528), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

Follow Up Inspections H-000074-14 and H-000075-14 were conducted concurrently with this inspection.

LV Feb 10/15

This inspection was conducted on the following date(s): February 19, 20, 21, 24, and 25, 2014.

This inspection was observed in part by Inspectors Kelly Hayes and Jessica Paladino.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Associate DOC, Resident Assessment Instrument (RAI) Coordinator, Food Services Manager (FSM), Activation/Environmental Manager, Registered Dietitian (RD), registered nursing staff, Personal Support Workers (PSW), unregulated staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed records including but not limited to health care records, meeting minutes and policies and procedures.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #319 used two bed rails in the raised position at all times when in bed and a wheelchair in a tilted position. Staff interviewed were aware of use of the rails and the tilted chair, which was an assessed need. The written plan of care, which provided direction to front line staff, did not include the use of the bed rails or the need for the wheelchair in a reclined position, which was confirmed during an interview with the registered staff. [s. 6. (1) (a)]

2. The resident was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #319 previously used a table top when up in the wheelchair at meal times, which was discontinued in 2013, as per the physician's order and clinical record. The plan of care available to staff on February 24, 2014, noted the current use of the table top. Interview with the registered staff confirmed that the table top was no longer in use and that the plan of care was not reflective of the current needs of the resident.
B. In February 2014, dentures for resident #350 were noted to be missing. Progress notes reviewed indicated that on February 20, 2014, registered staff submitted a referral to the dietary department to modify the resident's diet from regular to minced texture, due to the missing dentures. On February 21, 2014, the plan of care and the dietary list stated that the resident was on a regular texture diet. Direct care staff confirmed the resident was given a minced diet for breakfast on February 21, 2014. Interview with the registered staff confirmed that the plan of care was not revised to include the change in care need.
C. The plan of care in place for resident #349, on February 24, 2014, identified the need for a tilt wheelchair as a physical restraint, as per the physician's order. The order was discontinued in 2013, and the resident did not have any orders in place for a physical restraint as of February 24, 2014. The resident was using a tilt wheelchair at the time of the inspection as a Personal Assistance Services Device (PASD). The physiotherapist assessed the resident and identified the use of the tilted chair to support positioning. The plan was not revised when the purpose for the use of device changed and the physician's order was discontinued. [s. 6. (10) (b)]

3. When the resident was reassessed and the plan of care reviewed and revised because the care set out in the plan was not effective, different approaches were not considered in the revision of the plan of care.

A. A review of resident's #347 weight record for January 7, 2014, indicated a significant weight loss warning triggered for a 10 percent loss over a six month period. The MDS quarterly assessment completed by the RD on January 7, 2014, indicated a significant weight loss of 20 percent over 12 months and a Basal Metabolic Index (BMI) of 19.2. According to the plan of care the resident's weight was below the goal weight range (GWR), however the plan was to continue with the same interventions. The interventions were not evaluated for their effectiveness in relation to the ongoing gradual weight loss, the low BMI and the weight below the GWR as recommended by the RD.
B. A weight loss warning was triggered for resident #325 due to a 12 percent weight

loss over a six month period. A MDS quarterly assessment was completed on November 8, 2013, and the Resident Assessment Protocol (RAP) summary and the progress notes documented by RD indicated that "the current weight remains below GWR. Nutritional interventions are in place. Additional intervention is not realistic at this time due to resident refusal". The nutritional strategies were not revised over a six month period and outcomes were not evaluated, despite ongoing weight loss and monthly recorded weight below the GWR recommended by the RD.
C. A weight loss warning was triggered for resident #331 for a 7.5 percent significant weight loss over a three month period, from October to December 2013. The MDS quarterly assessment was completed on December 8, 2013. The RAP summary and the progress notes documented by RD had indicated "no significant weight variance for 1, 3, 6, and 12 months. Current weight remains within Goal Weight Range (GWR). The resident was responding to the interventions as outlined in the care plan. Resident's clinical assessment had not changed from the last assessment". The RD utilized the previous month's weight for December 2013 quarterly assessment and action was not taken despite significant unplanned loss weight over the three month period. [s. 6. (11) (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 there is a written plan of care for each resident that set out the planned care for the resident and that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary and when the resident is reassessed and the plan of care reviewed and revised because the care set out in the plan is not effective, different approaches are to be considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Where bed rails were used, the resident was not assessed and their bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

The home had a Facility Entrapment Inspection conducted on February 26, 2013, by an outside agency to identify any potential risks for resident entrapment, while in bed, with the bed systems in place in February 2013. Interview with the Activation/Environmental Manager identified that as a result of this external inspection the home changed the full bed rails on the beds to a half rail to reduce resident risk.
A. In February 2014, resident #319 used a specialized mattress and two half rails in the raised position when in bed. The plan of care and staff interview identified that this was a new mattress for the resident. There was no assessment of the resident for the use of the rails with the bed system evident in the clinical record. Interview with the registered staff and the Administrator/DOC confirmed that there was no formal assessment completed for the resident related to their bed rail use while in their bed system.
B. On February 20, 2014, it was noted that the resident #350's bed was against the wall and one half bed rail was in the raised position. During a review of the resident's clinical record, there was no evidence of an assessment related to the use of bed rails. Interview with Administrator/DOC confirmed that an initial resident needs assessment related to bed rail use, was not completed for the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the residents, 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 did not ensure that the home, furnishings and equipment were maintained in a safe condition and good state of repair.

A. On February 19 and 24, 2014, the following was observed in the home:
i. The paint in a number of bedrooms and bathrooms on the second floor was noted to be wearing and stained directly under the hand sanitizer dispensers.
ii. The carpets in an identified room were noted to be lifting and peeling away from the floor.
iii. The baseboards and walls in an identified bed/bathroom, were noted to be scuffed, exposing raw wood.
iv. Ceiling stains were noted in an identified room above bed numbers one and three.
v. Three out of four of the grab bars located on the walls in the third floor dining room were noted to be approximately 50 to 70 percent worn and chipped exposing raw wood.
vi. The third floor lounge chairs were noted to be worn and the yellow chair had a rip on the seat.
vii. The paint on the walls in an identified bedroom was noted to be chipped and scratched.
viii. There was a crack in the tiles running through an identified room, approximately one quarter inch thick.
ix. The door was falling off of the vanity in the second floor tub room. [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 to ensure that the home, furnishings and equipment are maintained in a safe condition and good state of repair, to be implemented voluntarily.

WN #4: 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 did not ensure that, the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home.

Resident #386 had a skin tear identified in 2014. As of February 24, 2014, there was no assessment of the resident related to the area of altered skin integrity completed by the RD in the clinical record. Interview with the Administrator/DOC confirmed that a RD assessment had not been completed nor was a dietary referral for the area of altered skin integrity located. [s. 50. (2) (b) (iii)]

2. The licensee did not ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were assessed at least weekly by a member of the registered nursing staff.

A. Resident #386 was identified to have a skin tear in 2014. This area of altered skin integrity was not assessed weekly by a member of the registered staff. A wound assessment was completed on February 6, 2014, and not again as of February 24, 2014. The Administrator/DOC confirmed that weekly skin assessments were not completed, as required for the resident.
B. Resident #325 had a staged pressure ulcer on the coccyx prior to January 2014. This area was not reassessed at least weekly by a member of the registered nursing staff. Record review completed on February 21, 2014 indicated that wound assessments were completed on January 1, 2014, January 15, 2014, January 22, 2014, February 5, 2014 and February 12, 2014, not weekly as required. [s. 50. (2) (b) (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 to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids were prepared and served using methods which preserved taste, nutritive value, appearance and food quality.

A. On February 24, 2014, observation of the noon meal service production, dining service and the dietary staff interviewed confirmed standardized recipes were not consistently followed. The consistency of the pureed and minced black beans and red peppers served to residents was runny on the plate. The prepared menu items served were liquefied, which reduced nutritive values, compromised taste, appearance and increased the residents risk for choking.
B. On February 24, 2014, the pulled pork served at lunch was stringy, glossy and sticky. The cook confirmed that the recipe was not consistently followed as some ingredients were substituted. The FSM confirmed that BBQ sauce was not in stock and as a result honey garlic sauce was substituted in the preparation of the pork. The food served to residents was not visually appealing. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are prepared and served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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:
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. Not all food and fluids were served at a temperature that was both safe and palatable to the residents.

The noon meal service was observed on the third floor on February 19, 2014.
A. PSW staff were serving regular texture soup from a black pot with a lid prior to 1200 hours. The pot was stored on a counter, not on a warming surface, after initial use. At 1228 hours resident #203 entered the dining room and was served the last portion of soup directly from the pot. The soup was not warmed prior to serving. Although there was an insufficient quantity of soup in the pot to take a temperature reading the soup was noted to be cool to touch by the inspector.
B. Resident #204 was served a meal tray in their room for the noon meal. The resident's meal of chili, a cornmeal muffin and turnips was portioned, plated and covered with a non-insulated lid and placed on a counter surface by the dietary aide at 1215 hours. The plated meal was served to the resident without being warmed or temperatures checked at 1233 hours, by the PSW. The chili was noted to be luke warm when checked by the inspector prior to being fed to the resident.
C. Three residents interviewed during the course of the inspection identified concerns with the temperature of the food served to them, identifying it was at times too cold.
D. Interview with the Administrator/DOC acknowledged an awareness of concerns related to food temperatures and identified this as one of the reasons for the change in meal service which was implemented on February 24, 2014. [s. 73. (1) 6.]

2. The licensee did not ensure that the appropriate furnishings and equipment were in resident dining areas, including comfortable dining chairs, tables at an appropriate height to meet the needs of all residents, and appropriate seating for staff that were assisting residents to eat.

During the noon meal service on February 24, 2014, resident #347 was observed sitting in a wheelchair that was positioned far away from the table and had an inadequate intake of the meal. Staff assisting confirmed that an appropriate table was not available and the resident was not able to reach the food to eat independently. The plan of care identified the resident required limited assistance with eating, however, due to furnishings available the resident was not able eat independently when observed. [s. 73. (1) 11.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #7: 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 did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Lingering offensive odours were present continuously, during each day of the inspection on the third floor in the hallway outside of resident #200's room and in residents #200 and #201 bed/bath rooms. Interview with Program/Environmental Manager confirmed that the home was aware of the offensive odours and that they have been ongoing for an extended period of time. It was identified that the home had previously replaced the flooring in these identified rooms, implemented additional cleaning and the use of deodorizers in these areas in an effort to address the odours. The odours continued to be offensive and constant in the identified areas despite the ongoing efforts of the home. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with conditions to which the licensee was subject.

Section 4.0 under Schedule B of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN), under the Local Health System Integration Act, 2006, reads "The Health Service Provider shall use the funds allocated for an Envelope for the use set up out in the Applicable Policy". The Long-Term Care Home Funding Policy of July 1, 2010, for Eligible Expenditures for Long-Term Care Home, Nursing and Personal (NPC) Envelope Section 1. b) reads "direct nursing and personal care includes the following activities: assistance with the activities of daily living, including personal hygiene services, administration of medications and nursing care".
PSW staff were observed to complete non nursing activities on February 19 and 20, 2014. PSW 's were observed to set the dining room tables on the third floor for the noon meal with table cloths, napkins and silverware, and portioned and served soup to all residents in the dining room. PSW staff interviewed confirmed that these activities were included in their job routines. Interview with the Administrator confirmed that the routines directed PSW staff, who were paid from the NPC envelope, to complete these non-nursing activities at the time of the observation. [s. 101. (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 to ensure that the home complies with conditions to which the licensee is subject, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program.

A. On February 19, 2014, registered staff were observed to administer a subcutaneous insulin injection and a variety of oral medications to five different residents. During the medication pass the staff touched two residents and handled a variety of tablets with their fingers. The registered staff was not observed to complete hand hygiene at anytime when the potential for cross contamination was present.
B. On February 21, 2014, at 0930 hour, it was noted that the hand sanitizer dispenser located at the main entrance of the home to be empty. The same dispenser was noted to be empty on February 21, 2014, at 1430 hours and on February 24, 2014, at 0830 hours. [s. 229. (4)]

2. Not all residents were offered immunizations against influenza at the appropriate time each year.

Residents #400, #401, #403 and #404 did not receive immunization against influenza for the 2013-2014 flu season. Immunization records, Community Care Access Centre (CCAC) vaccination history, and home admission checklists identified that the residents did not receive immunization against influenza. [s. 229. (10) 2.]

3. Not all residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with publicly funded schedules.

Residents #400, #401, #402 and #404 did not receive immunization against pneumoccocus in accordance with the publicly funded immunization schedules. Immunization records, Community Care Access Centre (CCAC) vaccination history, and home admission checklists all indicated that the residents were not offered the pneumoccocus, tetanus or diphtheria vaccinations. [s. 229. (10) 3.]

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 participated in the implementation of the infection prevention and control program and, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

On February 20, 2014, a half rail was observed to be in the raised position and against the wall for resident #350. The plan of care identified that a half rail was to be up in bed for safety to prevent falls. A consent for the use of the rail as a personal assistance services device (PASD) was not completed as required in section 33(4) of the Long-Term Care Homes Act. [s. 33. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that all areas where drugs are stored were kept locked at all times, when not in use.

On February 21, 2014 at 0940 hours, the door identified as the DOC office, which was utilized to store outdated and government stock medications was found to be unlocked and propped open with no staff in attendance of the office or stairwell. The office was not accessible to residents as required a code to unlock the key pad, however was accessible to staff and visitors of the home. [s. 130. 1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2013_214146_0064	168
O.Reg 79/10 s. 50. (2)	CO #001	2013_214146_0064	168

Issued on this 3rd day of March, 2014

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

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