Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2015	2015_267528_0023	H-003394-15	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the City of Brantford and the Corporation of the County of Brant
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET BRANTFORD ON N3T 1T5

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)

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): October 23, 26, 27, 28, 29, 30, and November 3, 4, 2015

This inspection was done concurrently with Complaint Inspection Log #'s 003284-15 and 015185-15 related to discharge and falls prevention management.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator-Acting, Director of Care-Acting (DOC), Medical Director, Nutritional Services Manager/Registered Dietician (RD), Support Services Supervisor, Nutrition Services Supervisor, Physiotherapist(PT), Restorative Care, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), maintenance, housekeeping staff, laundry staff, dietary staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_337581_0008	528
O.Reg 79/10 s. 36.	CO #002	2015_337581_0008	581

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. (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 2007, c. 8, s. 6 (4).
(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; 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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

From August to October 2015, resident #012 had multiple falls. The Falls Risk Assessment Tool from September 2015, indicated they were at risk of falling. Review of the written plan of care did not include the resident was at risk for falls. Interview with PSW #106 identified interventions for staff to monitor the resident and prevent falls. Interview with registered staff #101 confirmed that the resident was at risk of falling and the home had interventions in place but they were not documented in the written plan of

care as the planned care for the resident related to falls prevention and management. [s. 6. (1) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other.

In September 2015, the Minimum Data Set (MDS) Assessment and Resident Assessment Protocol (RAP) for resident #010 identified the resident was occasionally incontinent of bladder, and suggested the implementation of a prompted voiding schedule. On October 28 and 29, 2015, review of the written care plan and interviews with PSW staff #111 and #118 confirmed that the resident was occasionally incontinent and was not on a prompted voiding schedule. Interviews with registered staff #117 revealed that the suggested prompted voiding schedule was communicated to evening registered staff but a schedule had not yet been developed. Registered staff did not collaborate with each other in the development of a prompted voiding schedule for resident #10. [s. 6. (4) (b)]

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

A. Resident #022's plan of care stated they were to receive weight bearing support of two persons while dressing. The resident reported in an interview that at times, two staff did not provide assistance with dressing which caused discomfort in their arm. Review of point of care (POC) documentation completed by PSWs between in October 2015, revealed on 27 out of 57 occasions, the resident received one person physical assist with dressing. Interviews with PSW #132 and #133 confirmed that there were occasions when the resident received one person physical assistance with dressing and the plan of care was not provided as specified in the plan.

B. Resident #025 was identified as moderate nutritional risk as confirmed by the registered dietitian (RD). The resident's plan of care stated they were to receive a nutrition intervention at breakfast. On October 28, 2015, during a breakfast observation, the resident did not receive their nutrition intervention. Dietary staff #125 reported they were unaware of the intervention; however, confirmed it was listed on their breakfast serving notes and proceeded to offer the intervention to the resident. The RD confirmed the resident was to receive the intervention daily related to their nutrition risks. [s. 6. (7)]

4. The licensee failed to ensure that the resident was 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 #011's plan of care stated they were to receive limited assistance with eating at meals and a goal to maintain their weight.

i. On October 28 and 29, 2015 during lunch, the resident was observed receiving extensive to total assistance. Point of Care documentation completed by PSWs from September 28 to October 27, 2015, revealed the resident received extensive to total assistance on 41 out of 60 times during the reviewed period. Interviews with PSW #127 and #128 reported the resident regularly required extensive to total assistance for at least one to three months. Interview with the registered dietitian (RD) confirmed the resident required total assistance with eating at times as they had a change in condition, and the plan of care was not reviewed and revised when the resident's care needs changed.

ii. Review of the resident weights revealed they did not meeting their weight goal in September and October 2015. Progress notes from the RD in September and October 2015, indicated the resident's status declined. Interview with the RD who reported the resident had a change in condition, that their care needs changed and the plan goal was no longer necessary.

B. Resident #025's plan of care stated they required extensive assistance with eating. During lunch on October 23, 2015, and breakfast on October 28, 2015, the resident was observed receiving total assistance with eating. Point of Care documentation completed by PSWs from October 1 to October 28, 2015, revealed the resident received total assistance on 55 out of 57 times. Review of Minimum Data Set (MDS) coding from February to August 2015, also revealed the resident regularly received total assistance with eating. PSW #135 and registered staff #138 reported the resident regularly received total assistance with eating for the previous three to five months. Interview with the registered dietitian (RD) confirmed the resident needed total assistance with eating for approximately a year and the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (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 the following:
i. there is a written plan of care for each resident that sets out, the planned care for the resident
ii. the care set out in the plan of care is provided to the resident as specified in the plan
iii. the resident is 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, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy was complied with.

The licensee did not ensure that the policy " Head Injury Routine, # 3-I-40", revised on February 2014, was complied with.

The policy stated that a head injury routine would be carried out for 24 hours and the result of the assessment would be documented on the Glasgow Coma Scale (GCS) form when a resident reported they have hit their head or if the fall was unwitnessed. Frequency of conducting the assessment was to be completed every 60 mintues for the first four hours, a minimum of every four hours for the next 20 hours, for a total of 24 hours.

A. In October 2015, resident #012 had unwitnessed falls. Review of the clinical records indicated that a GCS documentation was started immediately after the falls, but were not completed every sixty minutes for the first four hours and a minimum of every four hours for the next twenty hours. This was confirmed by registered staff #114.

B. In October 20, 2015, resident #027 had an unwitnessed fall. Review of the clinical records indicated that a GSC documentation was initiated immediately after the fall, but was not completed every sixty minutes for the first four hours and a minimum of every four hours for the next twenty four hours. This was confirmed by registered staff #114. [s. 8. (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 where the Act or this Regulation requires the licensee to have or put in place any policy, procedure or strategy, that the policy, procedure or strategy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. 1. The licensee failed to ensure that residents were provided with foods that were safe.

A. On October 23, 2015, autumn spice cake was on the planned menu for lunch. During the lunch meal service, puree cake was observed pre-portioned as a whole piece of cake soaking in milk. Resident #025, who required a puree diet related to a swallowing risks, was observed eating the cake soaked in milk. PSW #106 reported they mashed up the cake in milk before serving it to the resident. Despite mashing, the puree cake contained pea sized lumps, as confirmed by the PSW. The dietary services supervisor reported the home had a generic recipe for puree cake to be soaked in milk; however, confirmed the autumn spice cake could not be manually mashed to achieve a safe, smooth consistency.

2. The licensee failed to ensure that residents were provided with foods that were adequate in quantity.

A. On October 23, 2015, puree garden and puree cucumber salad were on the planned menu for lunch. During the lunch meal, resident #025, #030 and #031 were observed consuming puree salads. The salad portions appeared small. Interview with dietary staff #125 reported they did not use a # 12 therapeutic scoop to ensure residents received appropriate quantities of food.

B. On October 29, 2015, puree egg and bread (combined) was on the planned menu for breakfast. During the breakfast meal, resident #025, #030 and #031 were observed with visibly small portions of the item. Dietary staff #125 reported the three residents required puree texture diets and they provided one to one and a half #12 scoop portions to each resident. Review of the therapeutic menu stated the puree portion was two #12 scoops. The dietary staff reported they were aware they did not have enough food prior to service and reported it to the staff who prepared it. When asked if they received additional amounts of the item, the dietary staff responded no, and that the residents probably

would not eat it anyway. Review of the production sheet also indicated only one puree serving was required for the specific dining room.

C. On October 29, 2015, during breakfast meal service, regular bananas were offered to residents; however, resident #025 and #030 who required puree texture were not offered banana. Dietary staff #125 reported puree banana was not offered to residents unless it was a special order item. This was confirmed by the nutrition services supervisor.

The registered dietitian (RD) confirmed that insufficient portions or items not being offered in all textures would not ensure that the residents were meeting their nutritional needs. [s. 11. (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 residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu items were prepared according to the planned menu.

A. On October 28, 2015, puree quiche was on the planned menu. During the lunch meal, puree quiche was served to resident #017 and #032. PSW #122 assisting resident #032 stated the quiche was clumpy and they needed to mix the puree salad into the quiche to make it easier and safer for the resident to swallow. The inspector observed and sampled the quiche which was notably sticky and did not clear easily from the mouth when swallowed. Dietary staff #123 who prepared the puree quiche reported they did not reference the recipe and confirmed puree quiche was to be smooth and not sticky.

B. On October 29, 2015, puree bread and egg was on the planned menu. During the breakfast meal, the puree item provided to resident #031 appeared sticky, as reported by PSW #134. Interview with dietary staff #137 reported they prepared the item; however did not follow the recipe. [s. 72. (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 all menu items are prepared according to the prepared menu, 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, were fully respected and promoted.

On October 28, 2015, medication packages containing residents names medications and medication dosages were observed in the medication cart waste bin on Cockshutt Place. Interview with RPN #116 confirmed the waste from the medication cart was added to the general garbage and could not identify any strategies to ensure Public Health Information (PHI), specifically resident names, medication, and dosages on pharmacy medication packages, were kept confidential. Interview with RPN #115 on Grand Terrace identified that they cut the resident name from the medication packet before disgarding in the garbage; however, a package was found in the medication cart waste basket containing a resident name medication and dosages. Interview with Acting Administrator revealed that staff were provided direction from the pharmacy to cut off the resident name from the package to ensure PHI was kept confidential. [s. 3. (1) 11. iv.]

WN #6: 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 failed to ensure that the home, furnishings and equipment were maintained in a good state of repair.

In October and November 2015, vinyl covering on resident #014 and #027's wheel chair arm rests were observed torn and cracked. Nursing staff #131 reported that damage noted to a resident's wheelchair was to be reported to registered staff and entered in the Shoppers Home Health Care portal to allow the home to track their maintenance status. Nursing staff #131 observed both chairs, confirmed the arm rests were not in a good state of repair and confirmed no entries were included in the portal regarding their maintenance or repair status. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails.

Resident #019 was observed on October 26 and 27, 2015 with long, broken and dirty fingernails. The resident stated their nails had not been cut recently. Registered staff #113 stated that the resident's nails would have been cut on bath days and confirmed that the resident's nails were dirty, broken and long and fingernail care had not been provided to the resident. [s. 35. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

During the initial tour of the home on October 23, 2015, one unlabelled used hair brush was observed in the Grand Terrace shower room, three unlabelled used hair brushes and several used combs were observed in the Mohawk Terrace tub room, and one unlabelled used hair brush was observed in the Davis Court shower room. On November 4, 2015, four unlabelled hair brushes were observed in the Davis Court tub room as confirmed by PSW #136 and three hair brushes and several used combs in the Mohawk Terrace tub room as confirmed by PSW #134. Registered staff #126 confirmed that resident's personal items, including brushes should be labelled. [s. 37. (1) (a)]

WN #9: 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 residents with a change of 5 per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #021's clinical record was reviewed and revealed that they experienced an increase in weight in August 2015. Review of the resident's clinical record did not indicate an assessment was completed regarding the change. Registered staff #110 reported the home's expectation was to assess reasons for the change in weight, and if required, submit a referral to the registered dietitian (RD) for further assessment. Registered staff #110 confirmed no assessment was completed by nursing staff nor was a referral sent to the RD. The RD also confirmed they did not assess the resident as they did not receive a referral. [s. 69. 1.]

WN #10: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that daily menus were communicated to residents.

On October 29, 2015 during a breakfast observation on Mohawk Terrace, no daily menu was posted for breakfast. Interview with the Food Service Supervisor confirmed the home did not post daily menus for breakfast. [s. 73. (1) 1.]

WN #11: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

The home's policy, "General Cleaning and Disinfecting of Equipment, Policy No, 2-A-50" last reviewed June 2013, stated night staff have a cleaning schedule to ensure wheelchairs are cleaned regularly and if wheelchairs are soiled, nursing or housekeeping are to clean immediately.

i. On October 23, 27, 28 and 30, 2015 resident #025's wheel chair was observed visibly soiled with dry fluid stains on the cushion, debris on the chair frame and arm rests. On November 3, 2015, the cushion appeared clean however the frame remained soiled. Interview with registered staff #138 confirmed the chair was visibly soiled and the home did not ensure the resident's chair was kept clean.
ii. On October 23, 27 and November 3, 2015, resident #027's wheel chair was observed visibly soiled with heavy dry and fluid stain debris on the frame and soiled seat cushion. Review of the home's wheelchair cleaning schedule on November 3, 2015 indicated the chair was cleaned once in October 2015. Interview with registered staff #138 confirmed the chair was visibly soiled and the home did not ensure the resident's chair was kept clean. [s. 87. (2) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was absent from the home the resident's physician or a registered nurse in the extended class attending the resident informed the licensee to discharge the resident and that the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

On February 20, 2015, resident #074 was transferred to the hospital for assessment and admitted for medical reasons. Three days later the home discharged the resident due to safety concerns of residents, visitors, and staff. Review of the resident's clinical health record and hospital physician documentation confirmed that when the the resident was discharged, they were absent from the home and remained in the hospital for medical reasons; however, the physician attending the resident did not discharge the resident (the person permitted to discharge the resident when absent from the home). [s. 145. (2) (b)]

WN #13: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Surveillance of Health Care-Associated Infections In Patient and Resident Populations, Third Edition, dated July 2014, recommends Long Term Care Homes have a surveillance System to monitor and analyze infections, including but not limited to, the documentation of new symptoms of infection every shift.

In August 2015, resident #028 began displaying symptoms of possible upper respiratory infection. The resident than began treatment for a respiratory infection. Review of clinical documentation revealed that staff were not consistently monitoring nor documenting symptoms of infection on every shift. Interview with registered staff #110 confirmed that staff were not documenting symptoms every shift. [s. 229. (5)]

Issued on this 16th day of November, 2015

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

Original report signed by the inspector.