Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 6, 7, 2015	2015_405189_0008	T-2471-15	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

KIPLING ACRES
2233 KIPLING AVENUE ETOBICOKE ON M9W 4L3

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

NICOLE RANGER (189), NITAL SHETH (500), SARAN DANIEL-DODD (116), SHIHANA RUMZI (604)

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): May 19, 20, 21, 22, 25, 26, 28, 29 and June 1, 2015

The following Complaint inspections were conducted concurrently with this RQI: T-1259-14, T-1959-15
The following Critical Incident inspections were conducted concurrently with this RQI: T-1505-14, T-2211-15

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Nursing (A)DON, Building Service Manager, Nutrition Managers, Nurse Managers, Acting Building Service Manager, Senior Clerk, Counsellor, Volunteer Coordinator, dietitian (RD), support assistant resident trust, physiotherapist (PT), activation aide, physiotherapy assistant, housekeeper, infection prevention and control coordinator (IPAC), Family Committee President, Resident Council President, registered staff, personal care assistant (PCA), residents and family members

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Trust Accounts

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

10 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 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.

On an identified date in May 2015, at 12:00 p.m., on an identified dining room, the inspector observed an identified registered staff scrape food and fluid from resident #006's face around the mouth and then proceeded to feed the scraped food and fluid back to the resident.

The inspector also observed two identified PCA's scrape food from resident #015, and #016's face around the mouth and the proceeded to feed the scraped food back to residents.

Interview with the nutrition manager and registered dietitian confirmed that staff scraping the food from resident's face around the mouth and feeding that food back to residents is not acceptable and resident should be treated with respect and dignity. [s. 3. (1) 1.]

2. Review of the written plan of care for resident #037 indicates that the resident requires one person physical assistance to take the resident to the washroom, supervise the resident to transfer on and off the toilet. At night, the resident uses an incontinent product.

Staff interview and resident interview confirmed that on an identified date in November 2014, resident #037 required assistance with toileting and activated the call bell. An identified personal care assistant (PCA) entered the room to assist the resident to the toilet. Resident #037's son who was present in the room, observed the PCA bringing the resident to the toilet and once completed, returned the resident back to the room. A short time later, resident #037 required assistance with toileting again and activated the call bell. The identified PCA re entered the room and informed the resident and son that the resident has an "incontinent product and can use that in case of emergency" and left the room to assist another resident.

Interviews held with the unit Nurse Manager and Administrator confirmed that the allegations were founded and constituted a lack of dignity and respect under the Resident's Bill of Rights. The PSW was provided additional training by the Home. [s. 3. (1) 1.]

3. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

During an interview with resident #036 on an identified date in May 2015, the resident reported to the inspector that when he/she is using the toilet in his/her washroom, he/she pulls the sliding door on both sides to provide privacy, however, one of the sliding doors does not stay shut thus providing no privacy. The inspector observed that one of the resident's sliding door in the washroom does not closed fully and retracts back and remains in a fixed position with a wide opening, providing no privacy for the resident. The resident reported to the inspector that he/she had informed the nursing staff on the unit and the Building Service Manager about this issue on multiple occasions.

Interview held with the Building Service Manager and an identified PCA, confirmed that the resident informed the staff that the door is not functional, and several attempts to fix the door was made with no success. A temporary solution was found on an identified date in May 2015, where a magnetic lock was put into place to keep the sliding door close while using the washroom. Interviews with the Building Service Manager and an identified PCA confirmed that the bathroom door was not functional and that privacy was not provided to the resident. [s. 3. (1) 8.]

4. The licensee has failed to ensure that 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 of residents is fully respected and promoted.

On an identified date in May 2015, at 10:00 a.m., on an identified unit, the inspector observed an unattended care cart in the hallway with a prescribed shampoo with a label for resident #014, displaying the resident's name, name of the shampoo and dosage . The inspector did not observe staff near or around the care cart and the cart was left unsupervised.

Interviews held with the registered staff and the Acting Director of Nursing (A)DON) confirmed that that the prescribed shampoo should not be left unattended on the cart, and the staff should return the shampoo to the charge nurse after each use to maintain the resident's privacy. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of resident are fully respected and promoted: 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, Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs and , that every resident have the 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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 is a written plan of care for each resident that sets out (c) clear directions to staff and others who provide direct care to the resident.

On an identified date in May 2015, during the initial tour of the the home, inspectors #116 and #500 observed isolation precaution signs posted outside resident #024, #025 and resident #026 bedroom door.

An interview carried out with the homes Infection Control Coordinator identified resident #024, #025, and #026 were isolated due to an identified condition. Record review for resident #024, #025 and #026 revealed there was no written plan of care in place which indicated the residents' had been diagnosed with an identified condition.

Interviews held with an identified RPN and the Infection Control Coordinator, confirmed that the residents' were diagnosed with an identified condition. The residents' written plans of care did not identify the identified condition nor provide clear direction to the staff. The registered staff and ICP coordinator immediately developed the plans of care for the three residents after the inspector brought this to their attention. [s. 6. (1) (c)]

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

Review of the written plan of care for resident #037 indicates that the resident requires one person physical assistance to take the resident to the washroom, supervise the resident to transfer on and off the toilet, as resident is on a scheduled toileting plan. At night, the resident uses an incontinent product

Staff interview and resident interview confirmed that on an identified date in November 2014, resident #037 required assistance with toileting and activated the call bell. An identified PCA entered the room to assist the resident to the toilet. Resident #037's son who was present in the room, observed the PCA bringing the resident to the toilet and once completed, returned the resident back to the room. A short time later, resident #037 required assistance with toileting again and activated the call bell. The identified PCA re-entered the room and informed the resident and son that the resident has an "incontinent product and can use that in case of emergency" and left the room to assist another resident.

Interviews held with the unit Nurse Manager and an identified PCA revealed that the resident is toileted and does not use the incontinent product as his/her method of continence. The unit Nurse Manager and Administrator confirmed that the care set out in the plan of care was not provided to the resident. [s. 6. (7)]

3. On an identified date in May 2015, at 10:17am, the inspector observed resident #039 sitting in his/her broda chair in the tv lounge on an identified unit without his/her equipment for an identified medical condition applied or in place. The inspector observed the resident for a short duration and then approached an identified registered staff about the use of the equipment for an identified condition for the resident. At 10:25am, the inspector observed the identified registered staff place the equipment for resident #039.

The written plan of care for resident #039 indicates that the resident requires the equipment on a continuous because he/she becomes confused, restless and diaphoretic

related to identified conditions. The written plan of care directs the staff to administer the equipment as ordered.

Interviews held with the two identified registered staff members present on the floor that day, revealed that the equipment needed to be replenished on a morning in May 2015. The equipment was applied to the resident in the morning and during breakfast, and was taken off on/around 9:30 am when the resident was placed in the tv lounge after breakfast. Interviews held with the registered staff, Acting Director of Nursing and Unit Nurse Manager confirmed that there was a length of time that the resident did not receive his/her equipment for an identified condition and the resident did not receive care as specified in the plan. [s. 6. (7)]

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

On an identified date in May 2015, during an interview with resident #023, the resident reported to the inspector that he/she would like a sling for his/her identified arm to be supported. The inspector observed the identified arm appeared swollen and was not supported. The resident stated he/she had lost movement to his/her identified arm due to an identified condition prior to admission to the long-term care home.

Record review for resident #023 revealed that a physician's order dated in April 2012, directed the staff to keep the resident's arm elevated. Review of the written plan of care did not have this direction to keep the residents arm elevated.

An interview with an identified RPN confirmed there was no information in the plan of care directing staff to ensure the identified arm is supported and immediately developed the plans of care for the resident after the inspector brought this to their attention. [s. 6. (7)]

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

A review of resident #006's nursing and personal care record from March 1 to May 24, 2015, revealed the following provision of care related to documentation :
Finger nails was documented only for three days on March 10, 17, 24, 2015.
Bathing/ shower care was not documented on May 5, 8, April 7, 21, 24, 28, 2015.

A review of resident #013's nursing and personal care record revealed that the resident's turning and repositioning schedule worksheet were not been completed on:
May 1, 2, 3, and 10, 2015, between 10:00 pm to 6:00 a.m.
May 9 to 10, 2015, at 2:00 p.m.
May 15, 2015, between 8:00 to 2:00 a.m.
May 16 and May 17, 2015, from 4:00 to 10:00 p.m.
April 10, 2015, from 12:00 to 6:00 a.m.
April 11, 2015, from 8:00 a.m. to 2:00 p.m.
April 15, 2015, from 8:00 a.m. to 2:00 p.m.
April 24, 2015, from 4:00 p.m. to 6:00 a.m.
April 25, and 26, 2015, at 2:00 p.m.
April 29, 2015, from 8:00 a.m. to 2:00 p.m.
March 6 and 7, 19, and 31, 2015, from 12:00 to 6:00 a.m.

Interviews held with the identified PCAs confirmed that above missing documentation should be completed by the PCA staff, however the care was provided to the resident. Interviews with an identified registered staff and the unit nurse manager confirmed that PCAs should complete documentation for nursing and personal care within their shifts. [s. 6. (9) 1.]

6. The licensee has failed to 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, the resident's care needs change or care set out in the plan is no longer necessary.

The written plan of care for resident #013's indicates that the resident should be provided functional exercises two times a week by the physiotherapist. The resident can be verbally abusive and resistive and will need a strategy of solving math questions to keep his/her mind off from resisting the exercises. The resident should be provided with a specified therapy.

Interview with the physiotherapist confirmed in December 2014, he/she discharged the resident as the resident was not cooperative for the exercises and he/she did not revise the plan of care.

Interview with the complimentary care staff confirmed that he/she discharged the resident in February 2015 as the resident kept refusing therapies and he/she did not revise the plan of care.

Interviews held with the registered staff and the acting DON confirmed that the plan of care should have been revised when the care set out in the plan is no longer necessary. [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 that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, that the provision of the care set out in the plan of care is documented and, that 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 #3: 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 has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On an identified date in May 2015, an identified housekeeper entered the medication storage room in the basement with the key while the inspector was inside. Upon inquiry, the housekeeper stated that he/she gained access to the medication storage room with the building services manager's key to store medication supplies. The inspector observed that the housekeeper had no nursing supplies with him/her.

An interview held with the building services manager confirmed that he provided the keys to the housekeeper for the purpose of accessing the nurses storage room. The building service manager further confirmed that the general master key provides access to the medication storage room and has allowed him/her access to the medication storage room ever since the new building opened.

Interviews held with the Administrator and Acting DON confirmed that only registered staff members, DOC and the Administrator are to have access to areas where drugs are stored. The Administrator further revealed that the home has been experiencing deficiencies with the programming of the master keys and areas that they provide access. The Administrator contacted corporate office to resolve the deficiency. [s. 130. 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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs, and the Administrator, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date in May 2015, the inspector was conducting an interview with an identified registered staff, when resident #040 approached the nurse and stated " I am ready for my medication now, but not the medication that was left at my beside table this morning". The inspector spoke with the resident regarding this incident, and the resident informed the inspector that he/she found two packages of medication at his/her bedside in the morning and provided the packages to the management team.

Record review for resident #040 revealed that in April 2015, an order was written by the physician for the resident to receive an identified medication by mouth three times a day. The inspector spoke with the unit manager and requested to see the medication that was found by the resident. The inspector observed two intact packages of an identified medication for the identified date in May 2015 0800hr and 1400hr. Interviews with unit manager and Acting Director of Nursing confirmed that the resident did not receive his/her medications in accordance with the directions for use specified by the prescriber [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence -based practices, and if there are none, in accordance with prevailing practices.

Review of the Toronto Public Health Tuberculosis (TB) screening recommendations in Long Term-Care Facilities dated April 18, 2013, recommends that TB screening for all new residents older than 65 years of age, that a chest x-ray is taken, based on the history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. Tuberculin Skin test is not recommended to

be routinely done upon admission for residents 65 years of age or older.

Record review for resident #027, admitted to the home in July 2014, and resident #029, admitted to the home in June 2014, reveled the residents received 2 step mantoux skin test within 14 days of admission.

An interview held in June 2015 with the Acting Director of Nursing confirmed that the home does not screen new residents for TB as per evidence based Toronto Public Health guidelines, and the Infection Prevention and Control program was not evaluated and updated at least annually. The ADOC revealed that the last evaluation of the program was conducted in 2014. [s. 229. (2) (d)]

2. The licensee has failed to ensure that the designated staff member who co-ordinates the infection prevention and control program has the education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management

An interview held in May 2015 with the Infection Prevention and Control Coordinator revealed that he/she does not have education in the following requirements: infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; and outbreak management.

An interview with the homes Administrator in May 2015 confirmed the Infection Prevention and Control coordinator did not have the education as required, and that the Infection Prevention and Control coordinator is enrolled for the Infection Prevention and Control education course to start in September 2015. [s. 229. (3)]

3. The licensee has failed to ensure that the staff participate in the implementation of the infection prevention and control program.

On an identified date in May 2015, the inspector observed signage for protective personal equipment (PPE) to be used outside of resident #026's room. Upon inquiry, two registered staff members indicated that the resident previously had an identified condition but were unsure if the resident was still had the diagnosis. An interview held with the

assigned PSW confirmed that he/she wears PPE's while providing direct care to the resident as the resident has an identified condition which continuously returns. Interview with a registered staff member revealed that the lab result is required to be negative in three consecutive tests prior to removing the PPE precaution. As of an identified date in May 2015, the resident had only received two lab results.

An interview with the DOC confirmed that the staff did not participate in the infection prevention and control program in managing the use of PPE's for management for resident #026's identified condition. [s. 229. (4)]

4. The licensee failed to 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.

The licensee policy directs the staff to conduct specific treatment activities to manage the specified condition .

On an identified date in May 2015, the inspector observed isolation precaution signs posted outside resident #024 and, #025 room door.

Record review for resident #024's lab results in March 2015 revealed resident was diagnosed for an identified condition. Prior swabs were taken in January 2015, and February 2015.

Record review for resident #025 lab results in April 2015 revealed resident was diagnosed an identified condition. Prior swabs were taken in March 2015 and April 2015.

Review of lab results showed that there was no further testing completed for resident #024 after March 2015 and for resident #025 after April 2015.

Interview with the IPAC coordinator confirmed the resident #024 and #025 were isolated and follow up screening as per prevailing practices was not carried out. The IPAC informed the registered staff to carryout lab requisitions to retest both residents [s. 229. (5) (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 the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; that the designate staff member to co-ordinate the program has education and experience in infection prevention and control practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; and outbreak management and, that on every shift, 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, to be implemented voluntarily.

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 has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On an identified date in May 2015, during the initial tour of the home the following areas were observed to not be kept in a good state of repair:
- in the spa room located on an identified unit a baseboard was observed to not be intact and had been adhered with duct tape.
- in the spa room located on an identified unit the ceiling paint was observed to be peeling and exposing the drywall above the shower stall and, small holes were observed in the drywall within the spa room.

An interview with the building services manager stated that the spa and tub rooms are inspected on a weekly basis to ensure functionality and any damage. The building services manager confirmed that the spa rooms were not kept in good repair. [s. 15. (2) (c)]

WN #7: 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:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On an identified date in February 2015, a complaint was received by the Ministry of Health and Long Term Care (MOHLTC) with concerns that an assigned PSW has rough handled resident #013's causing injury. The complainant notified this to the nurse manager and claimed that the complaint was not investigated.

A review of the progress notes for February 2015, indicates resident #013's family member approached the home and reported that the resident identified area were swollen because of an identified PCA providing care.

During an interview with resident #013's family member, he/she stated to the inspector that he/she reported this incident to the home.

A review of the home's policy #RC0305-00, entitled Zero Tolerance of Abuse and Neglect, revised January 10, 2014, reveals that staff are to conduct a full investigation and document the information including what occurred, when occurred, who was involved, including statement from all witnesses, where it occurred, written statements from all witnesses and residents, all significant information pertaining to the incident, actions taken t provide support to the abused and/ or neglected resident, that is change assignment, counselling provided.

Interview with the Administrator confirmed that there was no formal investigation completed for this complainant as the complainant was not the power of attorney, and the person who was the POA for the resident did not have any concerns with the identified PCA providing care to the resident. [s. 23. (1) (a) (i)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

On an identified date in February 2015, a complaint was received by the Ministry of Health and Long Term Care (MOHLTC) with concerns that an assigned PSW had rough handled resident #013's causing injury. The complainant notified this to the nurse manager and claimed that the complaint was not investigated.

A review of the progress notes for February 2015, indicates resident #013's family member approached the home and reported that the resident identified area were swollen because of an identified PCA providing care.

During an interview with resident #013's family member, he/she stated to the inspector that he/she reported this incident to the home.

A review of the home's policy #RC0305-00, entitled Zero Tolerance of Abuse and Neglect, revised January 10, 2014, reveals that staff are to conduct a full investigation and document the information including what occurred, when occurred, who was involved, including statement from all witnesses, where it occurred, written statements from all witnesses and residents, all significant information pertaining to the incident, actions taken t provide support to the abused and/ or neglected resident, that is change assignment, counselling provided.

Interview with the Administrator confirmed that a Critical Incident Report was not submitted to the Director (MOHLTC) as the complainant was not the power of attorney, and the person who was the POA for the resident did not have any concerns with the identified PCA providing care to the resident. [s. 24. (1) 1.]

WN #9: 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:

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).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey

Record review and interview with the Resident's Council President revealed that the Residents' Council was not given an opportunity to participate in developing the home's 2014 satisfaction survey.

An interview with the Administrator confirmed that the licensee did not seek the advice from the Residents' Council in developing and carrying out the 2014 satisfaction survey and acting on its results. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

Interview with the president of the Family Council confirmed that the home did not seek for their advice in developing and carrying out the satisfaction surveys in 2014.

Interview with the Administrator confirmed that the licensee did not seek the advice of the Family Council in developing and carrying out satisfaction survey in 2014 and acting on its results. [s. 85. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(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 has failed to ensure that procedures are developed and 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.

On May 22, 2015, the inspector observed three identified residents walkers, a wheelchair, and one geri-chair to be visibly soiled. The geri-chair of one resident was scheduled to be cleaned on May 12, 2015, and the other residents wheelchair was scheduled to be cleaned May 22, 2015. There was no schedule for one identified resident walker to be cleaned. The inspector observed the three identified resident's mobility devices over a course of three days, May 22, 24, and 26, 2015, on which the mobility devices continued to be in the same manner and visibly soiled.

Staff interview revealed that the mobility devices are on four week cleaning schedule and are cleaned by the evening housekeeping staff. The homes process is for the evening nursing staff to leave the scheduled mobility devices outside the unit doors were they are picked up by evening housekeeping staff to have them pressure washed and scrubbed. Once washed the mobility devices are left to dry in the basement and taken back to the same location on the units and left for the nursing staff to pick up.

Interview and observations of the three identified mobility devices by ADON on May 28th, 2015, confirmed that the three identified mobility devices were visibly soiled and does not appear to be cleaned by the staff. [s. 87. (2) (b)]

Issued on this 28th day of July, 2015

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

Original report signed by the inspector.