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
Feb 25, 2016	2016_431527_0001	035413-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

LEISUREWORLD CAREGIVING CENTRE - BRAMPTON WOODS
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

KATHLEEN MILLAR (527), BERNADETTE SUSNIK (120), DARIA TRZOS (561), MICHELLE WARRENER (107), SAMANTHA DIPIERO (619)

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): January 4, 5, 6, 7, 8, 12, 13, 14, 15, and 18, 2016

During the course of this inspection the following complaints and critical incident

inspections were conducted concurrently with the Resident Quality Inspection (RQI):

Complaints: H-001308-14; H-002551-15; and H-002756-15
Critical Incidents: H-001357-14; H-001383-14; H-001501-14; H-001667-14; H-001731-14; H-001996-15; H-002116-15; H-002058-15; H-002653-15; H-002702-15; H-003262-15 and Log #033666-15

The Complaint and Critical Incidents were inspected for the following: falls, pain management, skin and wound care, continence care and bowel management, falls, hospitalization and change in condition, infection prevention and control, and nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Assistant Directors of Care (ADOCs), Continence Care Lead, the Resident Assessment Instrument-Minimum Data Set (MDS-RAI) Coordinator(s), Fall Prevention Lead, the Infection Prevention and Control Lead, the Unit Coordinators, the Food Service Manager (FSM), the Registered Dietitian (RD), the Physiotherapist (PT), the Skin and Wound Care Lead, Dietary Aides, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers / Personal Care Attendants (PSWs/PCAs), the Housekeeping Aides, Environmental Services and Maintenance Manager, the Program and Services Manager, the Family Council President, the Residents' Council President, and the residents and families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping, maintenance, evaluated the sanitation and condition of equipment, furnishings and surfaces, the use and availability of disinfection agents and gloves, observed residents using their bed systems, reviewed documentation related to bed safety audits, clinical bed assessments, resident symptom monitoring, reviewed submitted outbreak incident reports, reviewed clinical records, the minutes for meetings, reviewed policies and procedures, reviewed clinical health records, reviewed meeting minutes, staff files, observed the provision of care, medication administration, and meal service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **21 WN(s)**
- **12 VPC(s)**
- **3 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized program of nursing and personal support services required under section 8 of the Act, that the program included relevant procedures and protocols and provided methods to reduce risk and monitor outcomes specifically related to urinary tract infections.

The nursing services required residents' needs to be assessed and that unregulated care providers be supervised in carrying out activities related to personal hygiene, activities of daily living and other duties as delegated.

The home's policy "Specimens, Swabs and Laboratory Reports (IX-E-10.60) dated January 2015", directed registered staff to "take specimens and swabs according to proper procedure and using personal protective equipment and precautions as indicated". According to registered staff, proper urine sampling procedure was a routine process that they were required to know as part of their profession and procedures for

taking various types of specimens and swabs were available in their laboratory forms provided by the laboratory. Delegation of the task to personal support workers (PSWs) was identified to be common practice in the home and registered staff confirmed that on many occasions, PSWs collected urine samples from residents during their morning routines.

According to laboratory procedures for taking urine specimens for testing, instructions were provided. The RNs reported that they showed the PSWs how to take the samples but that there was no supervision thereafter. Formal training on urine collection procedures was not provided until September 2015 to the PSWs and registered staff.

A review of the home's urinary tract infection statistics between January and December 2015, revealed that a number of residents had urinary tract infections each month. No baseline calculations were available to determine if the numbers were overly high or average for the population base. In reviewing the progress notes for various residents who had positive bacterial growth in their urine specimens and were treated with antibiotics, collecting specimens and other challenges were reported by staff. Two residents in particular were identified as residents #055 and #006.

A) Between January and December 2015, resident #055 was being routinely monitored and had a number of samples collected, several samples were positive for bacterial growth. In two cases, the laboratory claimed that there was an error on their part and the samples were repeated. According to the progress notes made by registered staff throughout this period, numerous accounts were made as to the difficulty staff had acquiring a sample. Laboratory results that indicated high bacterial growth led to additional testing as well as two separate transfers to the hospital.

B) During the last three weeks in October to the beginning of November, 2015, resident #006 exhibited symptoms typical of an infection. Staff documented in the progress notes that they had difficulty obtaining a sample due to the resident's resistive behaviour or refusal, and the sample was not attempted for 3 days each time. An alternative strategy was used with better success. The resident was sent to hospital on later date in November, 2015 and was admitted.

The home's policy did not include relevant procedures and protocols and methods to reduce risk and monitor outcomes specifically related to certain infections. No strategies or direction was available or implemented to address resident behaviours, how to manage situations when residents had inadequate output, how to ensure samples were

not contaminated (by contaminated gloves, collection devices, incorrect cleaning methods), when the use of a catheter was warranted, how specimens were to be collected if residents were not able to sit on a commode, proper storage of collected specimens and the proper storage of collection devices to avoid contamination. The overall outcomes related to specific infections were difficult to determine as the home was not evaluating and analyzing their data. (120) [s. 30. (1) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The infection prevention and control program did not include measures to prevent the transmission of infections.

A) The home did not have a supply of a sporicide available to disinfect touch point surfaces for instances when a bacterium known as C. difficile was being shed by residents. The bacteria is found in the gastrointestinal tract of individuals who have been on antibiotics over a long period of time. The bacterium produces a toxin or spore which is not susceptible to low level disinfectants which are typically used in long term care homes. Two cases were confirmed to be present in the home between December, 2015 and January, 2016. A review of the various types of disinfectants in the home revealed that no sporicide was available for use by housekeeping staff. Two different products were being used, neither of which had information on the label or manufacturer's website that they were adequate for use against C. difficile. Both were general bactericides. The infection control designate was not aware of the issue and assumed that the contracted housekeeping service hired by the licensee was aware. The housekeeping supervisor

was not aware of the difference between a sporicide and a bactericide and did not realize that C. difficile could not be eliminated by using a bactericide. Measures to ensure that staff were using the appropriate products for the target infection were not in place.

B) Various types of equipment and devices were not being cleaned and disinfected as required by the manufacturer or the home's equipment cleaning policies to reduce or prevent the transmission of infectious organisms.

i) The interior surface of tubs located in several home areas were observed to be dirty in appearance in January, 2016. A layer of soap scum and a black ring around the tub was evident and when scrubbed with a wet paper towel, the residue could be removed. According to the tub manufacturer and the home's tub cleaning protocols, the tubs were to be cleaned and disinfected between each use. The visible residue confirmed that this practice was not followed by the PSWs who bathed residents in the tubs. The continued use of dirty tubs placed residents at risk for the transmission of organisms that resided on the surfaces of the tub from resident to resident and would be re-introduced into the tub water once filled.

ii) The underside surface of tub lift seats located in several tub rooms were observed to have a moderate amount of residue, a combination of soap scum and bodily oils in January, 2016. On another date in January, 2016 the tub rooms on four units were inspected, and observed scum and residue on the bottom side of the tub lift seats. According to the tub lift seat manufacturer and the home's tub chair cleaning protocols, all sides of the tub chairs were to be cleaned and disinfected between each use. The visible residue confirmed that this practice was not being followed by the PSWs who bathed residents in the tub. The tub lift seat was designed to be lowered into the tub water while the resident sat on the seat. The resident could be transferred into the bath water or remain seated on the set. The tub water, containing organisms from the residents' skin and orifices could easily adhere to the surfaces of the tub lift seat and sides of the tub after each bath and be re-introduced into the tub water for the next resident, transmitting potential pathogens.

iii) According to a document titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013", non-critical devices such as bed pans, wash basins and urinals are to be cleaned and disinfected with a low level disinfectant after each use (unless the device is not used by any other person whereby cleaning is sufficient). Two wash basins located in the washroom on the second floor, and one basin in washroom on the third floor were observed to have visible residues on

them on several days in January, 2016. It was apparent that staff did not clean the basins after use or that PSWs were not monitoring the condition of the basins. No auditing or monitoring process was developed to ensure that personal care articles such as wash basins were being adequately cleaned and disinfected. According to the infection control designate, staff were required to wipe the basins out after use with a cloth or paper towel moistened with disinfectant (Virudex-7) and returned to a shelf under the vanity in the resident's bathroom. The Virudex-7 bottles were to be acquired from either the tub or shower rooms.

According to the home's policy for cleaning and disinfecting nursing supplies (V6-030), the wash basins were required to be cleaned in the soiled utility room using "germicidal disinfectant". When all five soiled utility rooms were observed, they were equipped with Virudex-7 disinfectant that had expired in November, 2014. They were located under cleaning sinks and were hooked up to dispensing systems which could dilute the chemical with water for the purposes of cleaning and disinfecting wash basins. However, based on staff information, basins were rarely cleaned in soiled utility rooms. The PSWs reported using the tub disinfectant or the bottles of Virudex-7 located in the shower rooms. The policy did not identify where exactly in the soiled utility room to clean the items (a hopper and large sink were available), if any brushes were to be used, how the dispensing system was to be used, how long the disinfectant was to remain on the items, whether the items needed to be rinsed after wards and how the item would be kept clean during storage. There appeared to be some confusion as to the process between the expectations and the written procedures developed. Without clear expectations for staff to follow and routine monitoring, devices such as bed pans and wash basins act as vehicles for the transmission of organisms, from one body area to another (in the case when wash basins used for bed baths) and from staff hands to other surfaces when not adequately cleaned and disinfected when necessary. Measures were not in place to monitor the cleaning and disinfection practices of staff to ensure that equipment and devices were adequately cleaned and disinfected.

C) According to the Provincial Infectious Diseases Advisory Committee document titled "Routine Practices and Additional Precautions in all Health Care Settings, 2012 (p.28)" the "indiscriminate or inappropriate use of gloves has been linked to the transmission of pathogens". During the inspection, boxes of disposable gloves could not be found other than on the medical carts of registered staff. The glove type was noted to be a non-sterile exam glove. When PSWs were asked where they obtained their gloves, they reported that they kept them in their uniform pockets. Further probing revealed that the PSWs each received a box or two once per month and that their boxes of gloves were then

taken to their lockers or to their home. Confirmation of this practice was made by registered staff and the Director of Care. Discussion was held regarding the high potential for the gloves to become contaminated before use and whether or not the type of glove was appropriate for the task. As best practices advises staff to wash their hands or use alcohol based hand rub before donning gloves in order to prevent the gloves from becoming contaminated, then the expectation is that the gloves be stored in a manner to prevent their contamination.

Practices that could lead to the transmission of infections in the home using contaminated gloves worn by PSWs included but were not limited to cleaning residents prior to acquiring urine and stool samples for culture, applying creams to the skin and assisting residents with oral hygiene. Measures were not in place to evaluate the storage practices of gloves and how the gloves were being used by staff and whether the type of glove being used was appropriate for the task. [s. 86. (2) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (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. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee did not designate a staff member to co-ordinate the program who had education and experience in infection prevention and control practices, specifically related to data collection and trend analysis.

Discussion with the designated infection prevention and control staff member revealed that they did not attend any educational classes or take any courses (on line or in person) or have experience related to surveillance (the systematic process of collection, collation and analysis of infection data) of health care associated infections. According to current prevailing practices, a document titled "Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011" developed by the Provincial Infection Diseases Advisory Committee, the establishment of a surveillance system is associated with reductions in infection rates, is required for resident safety and mandatory reporting requirements in Ontario and determining the effectiveness of the overall infection prevention and control program. [s. 229. (3)]

2. The licensee did not ensure that on every shift symptoms indicating the presence of

infection in residents were monitored in accordance with prevailing practices and that the symptoms were recorded.

A) Prevailing practices identified in a document titled "Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011" developed by the Provincial Infection Diseases Advisory Committee specifies that the onset date, resolve date, actions taken and symptoms of infection, are to be monitored and documented or recorded. The methods of monitoring and documentation may vary, however the licensee developed a policy IX-E-10.40 titled "Line Listing – Resident Surveillance" and form tilted "Infection control surveillance record" for use by registered staff to record the information as required in order to visually monitor the list for other residents with the same symptoms over the course of a specified time period. During the inspection, the licensee was not using the same form as outlined in their policy but was using a similar form titled "infection line listing". When reviewed for the month of January 2015, the line listings for each home area did not include any residents with symptoms of infections. The symptoms of infections were recorded electronically in individual resident progress notes which were not an ideal method of recording as it does not easily allow staff to monitor what trends or patterns were developing within one home area or throughout the home. The failure to adequately monitor resident symptoms from shift to shift and day to day could lead to outbreaks involving a large number of residents in a short period of time.

In January, 2015, an outbreak was declared by the local public health unit after receiving information from the licensee that residents had symptoms of an infection. By the end of January, 2015, there were cases on every home area. Manual and electronic line listings for the month of January, 2015 were reviewed; however the manual and original infection line listings for several units could not be located by the Infection Control Designate (ICD). According to the ICD, the hand completed forms were subsequently entered into an electronic data base by a designated person at the end of the month. The electronic forms included data from all home areas. Neither of the manual documents or electronic documents included any residents on the infection line list or surveillance record with any infectious symptoms. A separate infection line listing for public health was established, but only after a number of cases were identified and was subsequently used to continue monitoring resident cases.

A review of the progress notes was completed for a number of residents who were identified by registered staff to have had symptoms. Resident #049, #050 and #079 were sick on a specific date in January, 2015. Residents #020, #080, #081 and #025 were sick on a specific date in January, 2015. Resident #081 sat with their spouse #082 in a

different dining room on a specific day in January, 2015 and was sick in the dining room. Resident #082 became unwell in January, 2015. None of these residents had their symptoms documented on the infection line listing.

B) Residents who were observed to have contact precaution signage on their room doors during January, 2016 were not all recorded on the "infection line listing". Some home areas had an "antibiotic line listing and a "pressure ulcer line listing" located in the RNs binder. The documentation of infections on other forms was not specified in the home's infection prevention and control policies. Only one home area started an infection line listing by mid-January, 2016. A review of the residents' charts confirmed that the residents noted below were on contact precautions for antibiotic resistant organisms and were not captured on the appropriate line listing or any other listing kept by the RN in each home area.

Out of 9 residents on contact precautions, only 3 (#062, #083 and #084) out of the 9 residents were recorded on the January infection line list, and 5 (#022, #062, #063, #084, and #085) out of the 9 were recorded on the December infection line list.

The above residents and any others who were confirmed with a positive culture for any antibiotic resistant organisms would be required to be added to the infection line list and carried over from month to month until their infections were resolved. [s. 229. (5) (b)]

3. The licensee did not ensure that the information gathered under subsection 5 (symptoms of infection collected on each shift) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

The infection control designate was not able to provide any trends or infection rates from any particular surveillance period (day to day, month to month or year to year) for their infections in the home. The rates of infection were not calculated (per 1000 resident days) to establish a baseline of frequency and type of infection expected for the resident population base in the home. The data that was gathered on infection line listings for each home area listed only the total number of each type of infection. In some cases, symptoms of infection were not included on the line listing and were only found recorded in the resident progress notes. The data did not reveal whether the number of residents with clinical signs and symptoms of infection were reasonable over the course of an established surveillance period as no established internal or external benchmarks had been developed.

The home's policies titled "Line Listing - Resident Surveillance" originally dated June 2006, "Surveillance & Process of Data Collection" originally dated March 1997, and "Monthly Infection Control Summary Record" originally dated March 2002 and all revised January 2015 required that infection data be collected daily and analyzed daily and on a monthly basis to determine the incidence and prevalence of infections in the home. [s. 229. (6)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 a staff member is designated to co-ordinate the program who has education and experience in infection prevention and control practices, specifically related to data collection and trend analysis, to be implemented voluntarily.

WN #4: 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 the written plan of care set out the planned care for the resident.

A) Resident #005 was observed as being unshaven in January, 2016. An interview with Personal Support Worker (PSW) #128 indicated that staff "just know" when and how to shower the resident but indicated that instructions for doing so were not in the written plan of care. An interview with RPN #132 confirmed that the written plan of care did not include the resident's personal hygiene preferences. On review of the resident's plan of care it was determined that there were no entries that related to the residents personal

hygiene and grooming preferences, nor was there an entry in regards to the level of assistance the resident required to complete these tasks. An interview with the registered staff #104 confirmed that the written plan of care did not address the aspects of personal hygiene and grooming for the resident. (619)

B) Resident #043 required a mobility device, and had a history of frequent falls since admission to the home in April 2014. It was determined by the home's registered staff that the resident required a chair alarm as a preventative measure for falls. In September, 2015, the resident was placed in front of the nursing station for closer observation. Staff found the resident on the floor in front of the nursing station after an apparent fall; no injuries were incurred. During an interview with PSW #133 and registered staff #132, they were able to confirm that the resident used a chair alarm as an intervention to prevent falls on a daily basis, and indicated that this intervention should be included in the written plan of care. On review of the resident's written plan of care last updated August, 2014, the use of a chair alarm as a falls prevention strategy was not included. The resident's progress notes were reviewed and identified that the chair alarm was implemented in April 2014, however approximately 5 months later this was still not included in the resident's written plan of care. The Assistant Director of Care (ADOC) #104 was interviewed and confirmed that the chair alarm should have been included in the resident’s written plan of care, and that staff were expected to update the plan of care when there was a change in the resident’s condition or care needs.

C) Resident #008 had a pressure ulcer. The interview with the ADOC #105 indicated that the resident had a turning and repositioning system on their bed as an intervention to promote healing. The written plan of care was reviewed and did not have this intervention documented. The ADOC #105 confirmed that this should have been added to resident’s written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care for resident #055 set out clear directions to staff and others who provided direct care to the resident.

Resident #055 had a plan of care that included an individualized menu that was approved by the Registered Dietitian and the resident's SDM. A statement at the top of the individualized menu identified the resident was not to be served or limit specific foods. A dietary preference list was also in place for staff to reference when preparing and serving meals to the resident. The resident's written plan of care directed staff to follow the individualized menu at meals.

The resident's individualized menu included some specific food choices the resident disliked or was unable to eat. Direction was unclear if the staff were to follow and serve the items that contained the dislikes or foods the resident was unable to eat, or if they were to make substitutions. Staff preparing the meals identified the resident was not to have these items so substitutions were made. Standardized processes were not in place when substitutions were made (e.g. production sheets, recipes, approval by the Registered Dietitian and the resident's SDM).

The Registered Dietitian stated that substitutions were not to be made as the resident got upset when they were provided with a meal that was different than what other residents were receiving. At the observed lunch meal in January, 2016, the resident's planned menu included specific foods, which the resident was served while the other residents were served a different meal. The resident got upset during the meal and stated they did not like the plain food. At the observed lunch meal in January, 2016, the planned menu included specific type of soup. The resident was served a plain broth soup. At the dinner meal in January, 2016, both food choices contained a specific food the resident was not able to eat. Staff #163 was preparing the meal and stated that they made a substitution for resident #055 based on the resident's preferences. Production sheets did not include direction for staff to prepare an alternative food choice for the supper meal. The resident's menu directed staff to prepare and serve a specific food that the resident was not able to eat.

Clear direction related to the resident's preferences/avoidances was not provided for staff preparing and serving meals to resident #055. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care for resident #006 set out clear direction to staff and others who provided direct care to the resident.

Resident #006 required a blenderized menu with honey thickened fluids. The resident's plan of care included directions for staff on the quantity of fluid to add to each menu item to ensure the correct consistency of foods; however, written direction was not provided to staff related to the combination of foods being prepared. During interview in January, 2016, the Registered Dietitian stated the resident was to receive specified diet containing protein, and one containing another type of food with an additional nosey cup provided for dessert. Staff preparing and serving the meal for resident #006 in January, 2016, provided the dietary intervention, but combined the items differently. The Registered Dietitian confirmed that written directions were not in place for staff preparing and serving the blenderized meals to ensure the menu items were prepared consistently between

staff. [s. 6. (1) (c)]

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

The Registered Dietitian developed and implemented an individualized menu for resident #055, in consultation with the resident's substitute decision maker (SDM). The individualized menu was posted in the kitchen for staff preparing meals and in the servery for staff portioning and serving meals. The resident's plan of care directed staff to follow the individualized menu.

Staff preparing the resident's meals did not consistently follow the individualized menu, stating that the menu included foods that were noted dislikes or contrary to the resident's diet order. Substitutions were made; however, the substitutions were not planned on the daily production sheets and direction was not provided to the Cooks to make the substitutions.

During interview in January, 2016, the Registered Dietitian stated that significant restrictions related to the resident's restrictions and intolerances were not required except for what was marked on the individualized menu and stated that if there were concerns with items on the planned menu that should have been communicated back to the Registered Dietitian to ensure the plan of care was updated.

Staff did not collaborate with each other to communicate discrepancies between the resident's preferences and what was on the planned menu and to ensure standardized processes were in place if substitutions were required. [s. 6. (4) (b)]

5. 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.

In October, 2015 resident #006 was referred to the nurse practitioner after exhibiting specific symptoms. The registered staff #104 received orders to obtain a specimen for laboratory testing to confirm the presence of an infection, and an order and requisition for an x-ray. The resident was started on medication to resolve the infection, which was completed by the end of October, 2015. As per the progress notes in the resident's chart, the specimen was not collected and sent to the laboratory until the third week in October,

2015, three days after the initial order was made. An interview with PSW #128 stated that the resident at times could be resistive to care but was unable to identify interventions that would have enabled the staff to obtain the specimen in a timely fashion. An interview with registered staff #104 also indicated that because the contracted laboratory services provider regularly picked up specimens by 1100 hours daily, that if staff were unable to obtain the sample from the resident, they did not re-attempt sample collection until the following day. On review of resident #006's progress notes, the requisition for the x-ray was not faxed by any registered staff nor received by the x-ray service provider until the end of October, 2015, nine days after it was ordered by the nurse practitioner (NP). The resident received the x-ray in the first week of November, 2015; a total of sixteen days after the initial order was made. Registered staff #104 indicated that the delay in faxing the requisition was attributed to a manual staff error.

At the beginning of November, 2015 resident #006 was seen by the home's physician after exhibiting symptoms indicating an infection, which was not resolved. The physician ordered a second specimen to be collect, and began the resident again on medication for five days. According to the progress notes registered staff #104 attempted specimen collection twice, but was unsuccessful. The specimen was not successfully collected the end of the first week in November, 2015 at which time registered staff #104 obtained an order for in & out catheterization. The medication was completed; however the resident continued to exhibit signs and symptoms of an infection. The staff did not refer the resident to the NP or the physician for follow up. Near the end of November, 2015 the resident was transferred via ambulance to hospital and was admitted. On review of the home's policy titled "Laboratory Services" #V3-830, revised March 2012, identified that the "home will ensure that appropriate specific procedures are in place to track the timely completion of ordered laboratory tests".

An interview with the DOC confirmed that on the occasions where two specimens were ordered that the specimens should have been collected as soon as possible to minimize the risk of a negative outcome for the resident. The DOC indicated that it was not the home's policy or procedure to only collect specimens in the morning prior to laboratory specimen collection. The DOC also confirmed that the x-ray requisition should have been faxed to the service provider as soon as possible and that in not doing so there was the potential for a negative outcome for the resident in relation to a delay in treatment. The DOC confirmed the delay in the specimen collection twice, the lack of follow up to ensure that the infection had been adequately treated, and the resident's diagnosis in the hospital. Staff did not provide care to the resident as set out in the written plan of care.

(619)

B) Resident #006 had a plan of care that required specific consistency of fluids. The plan of care also included a serving of a nutritional supplement to be provided in the morning and at the evening snack pass. PSW #115 confirmed the resident's nutritional supplement was not thickened to the correct consistency the morning of snack pass in January, 2016. The Nutrition Manager confirmed the same day that clear direction was not provided to staff preparing the supplement as the individualized labels for the resident's nutritional supplement did not identify that the supplement was required to be thickened. The Registered Dietitian confirmed in January, 2016, that the resident's nutritional supplement should have been thickened to a specific consistency. (107)

C) The resident's plan of care included recommendations from the Speech Language Pathologist (SLP) related to oral care. Personal Support Worker #134 identified they provided oral hygiene in the morning and confirmed they were not providing oral care before and after meals. Documentation reflected that the resident was receiving oral hygiene twice daily and did not include before and after meals. The RAI-MDS Coordinator confirmed the resident's plan of care included recommendations for oral care before and after meals. (107) [s. 6. (7)]

6. 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 #008's written plan of care indicated that the resident had partial denture on top and natural teeth on bottom. The PSW #130 was interviewed and indicated that the resident had not worn dentures for approximately 2 years. The current written plan of care was reviewed and indicated that the resident still had partial dentures on top and natural teeth on the bottom. The ADOC #105 was interviewed and confirmed that the written plan of care should have been revised when the resident was no longer wearing dentures.

B) Resident #039 was hospitalized in July, 2015, and their condition had deteriorated. The hospital physician had deemed the resident as palliative care after discussion with the SDM. The hospital physician subsequently had a telephone conversation with the DOC in the first week of July, 2015, and they were reassured by the DOC that the home had a palliative care support team. The DOC subsequently communicated to the clinical staff the resident's change in status when he returned to the home mid-July, 2015. The

clinical record was reviewed and the plan of care from July, 2015 to January, 2016 had not been reviewed and revised to reflect the resident was palliative and comfort care. The DOC and ADOC #105 were interviewed and confirmed that the plan of care should have been reviewed and revised to reflect end-of-life care for resident #039.

C) Resident #067 sustained a fall in September, 2015. The resident was assessed by the Registered Physiotherapist at the beginning of September, 2015 and indicated that the resident required specific several fall intervention strategies. The progress notes and the written plan of care were reviewed and indicated that a few of the strategies were implemented after the fall. The flow sheets for September, 2015, indicated that one of the strategies were added to the Point of Care (POC). Three PSWs #115, #153 and #161 and one registered staff #132 were interviewed, but could not recall whether the resident had a specified fall prevention strategy in place after the September, 2015 fall, but had indicated that if it was in place it would have been added to the written plan of care and the flow sheets. The interview with the Physiotherapist confirmed that the charge nurse on the shift that day was informed of the new interventions that were recommended. The resident sustained two more falls, in September, 2015. One week later, the resident was transferred to the hospital. The resident had another fall while in the hospital and sustained an injury, then subsequently passed away. The resident's plan of care was not revised with the new interventions after the resident's fall at the beginning of September, 2015. [s. 6. (10) (b)]

7. The licensee failed to ensure that resident #055 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening over a 30 day period between December, 2015 and January, 2016. Documentation in the Point of Care (POC) system reflected the resident refused oral care in the evening on 16 days and one time on day shift over that 30 day period. PSW #165 was interviewed and confirmed the resident was very resistive to oral care in the evenings. Registered staff #167 confirmed they were not aware that the resident was routinely refusing oral care and stated that strategies in place on the resident's plan of care were usually effective methods. (107) [s. 6. (10) (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 (a) to ensure that the written plan of care set out the planned care for residents;
(b) to ensure that the plan of care for residents set out clear directions to staff and others who provide direct care to the residents
c) to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the residents' plan of care so that the different aspects of care are integrated, consistent with and complement each other
d) to ensure that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #5: 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. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) The home's policy and procedure "Palliative Care - Care of the Resident", number VII-G-30.30, and revised January, 2015, directed staff to ensure that all palliative residents

had comprehensive assessments and a current, up to date plan of care, which would be completed using an interdisciplinary approach. In addition, the policy identified that an interdisciplinary conference would be held to ensure that all of the resident's needs were planned for and able to be met. The plan of care did not reflect that resident #039 was palliative or end-of-life care. The DOC and ADOC #105 confirmed that the Palliative Care Program should have been implemented for the resident, and they should have started with an interdisciplinary care conference when he returned from the hospital mid-July, 2015. The DOC and ADOC #105 confirmed that the Palliative Care Program was not implemented for resident #039. The home was not compliant with their "Palliative Care - Care of the Resident" policy and procedures.

B) Resident #005 was observed by the LTC Inspector unshaven over a three day period in January, 2016. PSW staff indicated that shaving would be completed on bath days; however the PSW identified that the resident had been shaved once out of a possible four times in the past two weeks. PSW staff also indicated that the resident would sometimes display responsive behaviours and refused showers, personal hygiene and grooming care provisions. PSW staff indicated that when the resident refused care, they were responsible for reporting this information to the registered staff who would then document the refusal in the progress notes. The registered staff #126 was interviewed and confirmed that no entries related to the resident's refusals were documented over the past three months. The home's policy titled “Personal Care – Hygiene and Grooming”, number V3-212, and last revised April 2013, identified that "Male residents will be cued or assisted to shave daily or as per residents own documented routine" and that PSW staff were required to "report resident refusal re: grooming or hygiene to registered staff. Registered staff will document refusal and update care plan to reflect resident refusal". An interview with the home's ADOC #105 confirmed that the staff, both PSWs and registered staff, failed to comply with the home's personal hygiene and grooming policy.

C) The home’s policy called "Re-Admission from Hospital", policy # VIII-C-10.80, issued July 2004 and revised January 2015, directed staff to complete the RE-ADMISSION FROM HOSPITAL CHECKLIST upon return from hospital. The checklist indicated that on day 1 staff were to obtain specific swabs to rule out infection, and to document same.

Resident #008 was admitted to the hospital in September, 2015 and returned to the home several weeks later. A review of the progress notes indicated that on a specific day in September, 2015 the registered staff had documented that urine and swabs be collecte. There were no other progress notes indicating whether the swabs were taken after the resident returned from the hospital. The resident’s health records were reviewed

and no laboratory results from the collection of swabs were found.

The ADOC #105 was interviewed and confirmed that staff did not collect the swabs after the resident returned from the hospital as they were expected to according to the home's policy and procedures. (561) [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #6: 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. The licensee did not ensure that where bed rails were used, that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The licensee designated a registered nurse (RN) to assess all bed systems beginning in August 2015 for beds on the 1st and 2nd floors and ending in November, 2015 for beds on the 3rd floor. Using an appropriate measuring tool, the RN determined the entrapment status of all of the beds. Twenty-nine beds were identified to have failed one or more

zones of entrapment for zones 1-4.

At the time of inspection, the RN did not know the entrapment status of the twenty-nine beds as some beds were equipped with a new mattress and others had loose bed rails tightened, but had not been re-tested afterwards. All twenty-nine beds were confirmed to be equipped with at least one bed rail during the inspection and the majority were being used by residents for either repositioning or transferring. No bed accessories were observed to be in use to reduce zones of entrapment where necessary. No information was added to the resident's written plan of care about the status of their beds and what interventions needed to be applied. The RN confirmed that no interventions were instituted for the twenty-nine residents to ensure the beds were mitigated in some way to make them safer or why residents were not relocated to a passed bed. The following residents were observed:

A) Resident #012 was observed to be sleeping in a bed with both assist rails in the up position on a specific day in January, 2016. The bed failed entrapment zone 2 (between rail and mattress). The resident's plan of care confirmed that the resident required two bed rails for repositioning while in bed, however no information about the status of the failed bed and what mitigation was necessary was included or any information about the need for padded rails.

B) Resident #001 was observed to be sleeping in bed with both assist rails in the up position on a specific day in January, 2016. The bed rails failed zone 2. The resident's plan of care confirmed that the resident required only one rail on the right side for repositioning, however no information about the status of the failed bed and what mitigation was necessary was included or any information about the need for a padded rail.

C) Resident #049 was observed to be sleeping in bed with both assist rails in the up position on a specific day in January, 2016. The bed rails failed zone 2. The resident's plan of care confirmed that the resident required both rails for repositioning, however no information about the status of the failed bed and what mitigation was necessary was included.

D) Although residents were not in bed at the time of inspection, the following beds all failed entrapment zones 2, 3 or 4 and were observed to have at least one bed rail elevated or in the up position on specific days in January, 2016: #236B, #127, #124A, #121, #353, #324A and # 327. None of the beds had any entrapment mitigating

accessories applied. According to the RN, the bed rails were typically only used while the resident was in bed. Discussion was held regarding need for all health care staff to understand that rails should not be applied unless specified in the plan of care, typically when the resident was in bed due to the increased risk of entrapment on the identified beds.

In January, 2016, data was provided by the RN that all beds that had previously been identified as failing one or more zones (1-4) were re-tested on specific days in January, 2016. Seven beds were identified to have failed zone 2, 3 or 4. The residents were informed and some steps were implemented to remedy the bed system (new mattresses ordered, bed rails removed, beds switched). The three residents noted above had their beds re-tested and the beds passed zone 2 which was previously identified as having failed. [s. 15. (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 bed rails were used, that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment with respect to the residents mood and behaviour patterns, including any identified responsive behaviours, and variations in resident functioning at different times of the day.

On three specific days in January, 2016 resident #005 was observed as unshaven; hair growth was noted to be more than 2 days old. Resident #005 had a CPS score of 3/6 and required assistance from one staff in the form of supervision and cueing, which was scheduled to occur on shower days twice weekly. An interview with PSW #124 confirmed that the resident had been shaved in the first week in January, 2016 but not since then. PSW staff stated that in the evening the resident can become resistive to care because they were tired and therefore the resident will refuse personal hygiene and grooming assistance. An interview with RPN #126 confirmed that the resident had two referrals to the Behavioural Support Officer (BSO) for asessment, once in July, 2015, and recently in January, 2016, but confirmed that no updates to the written plan of care were completed including identification of behavioural triggers, behavioural patterns, or effective behavioural interventions. An interview with the homes ADOC #104 confirmed that the resident's plan of care was not based on an interdisciplinary assessment with respect to the residents mood and behaviour patterns. [s. 26. (3) 5.]

2. The licensee failed to ensure that the plan of care for the resident was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A) The plan of care for resident #007 included routine oral hygiene twice daily. On January 13, 2016, the resident's toothbrush was noted to be dry and unused. The PSW #115 providing care to the resident stated that they used a disposable sponge pack to clean the resident's teeth and did not use the resident's toothbrush. PSW #162 also confirmed that they used a disposable mouth sponge for cleaning the resident's teeth due to responsive behaviours. An interdisciplinary assessment of the resident's oral hygiene was not completed in relation to responsive behaviours, and in relation to the strategies that the PSW's used to provide oral care. Directions on the resident's plan of care were not consistent with the care being provided to the resident.

B) The licensee failed to ensure that the plan of care for resident #006 was based on an interdisciplinary assessment of the resident's dental and oral status, including oral

hygiene. The written plan of care for resident #006 did not include directions for staff related to oral hygiene. The resident was at risk, requiring good oral hygiene and the resident did not have teeth. [s. 26. (3) 12.]

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 plan of care iss based on, at a minimum, interdisciplinary assessment with respect to the residents mood and behaviour patterns, including any identified responsive behaviours, and variations in resident functioning at different times of the day, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to minimize the restraining of residents was complied with.

The home's "Personal Assistance Service Devices (PASD's)", number VII-E-10.10 and revised November, 2015, directed staff were to evaluate the use of PASDs using the "Restraint/PASD" electronic assessment form.

A) Resident #037 was observed in a tilt wheelchair on four days in January, 2016. The registered staff #120 and PSWs #147 and #150 confirmed that the resident was in a tilt wheelchair for repositioning and it was identified as a PASD. The resident's "Restraint/PASD" electronic assessment forms were reviewed for September and December, 2015, which identified there was no assessment for the tilt wheelchair. The ADOC #105 confirmed that the assessments for PASD were expected to be documented in the "Restraint/PASD" electronic assessment form in Point Click Care (PCC), and it was not done for this resident.

B) Resident #008 was observed in a tilt wheelchair on a specific day in January, 2016. The registered staff #136 and a PSW #116 confirmed that the resident was in a tilt wheelchair for comfort and repositioning, and they identified that the tilt wheelchair was a PASD. The resident's health records were reviewed and identified there was no PASD assessment for the tilt wheelchair. The ADOC #104 confirmed that the assessments for PASD were expected to be documented in the "Restraint/PASD" electronic assessment form in Point Click Care (PCC), and it was not done for this resident. (527)

C) The plan of care for resident #007 included a tilt wheelchair for use as a PASD. The home's policy, "Personal Assistance Service Devices (PASD's), number VII-E-10.10", revised November, 2015, directed staff to evaluate the use of the PASD quarterly until no longer required and to document on the electronic assessment form.

An assessment of the the tilt wheelchair was not completed using the home's standardized assessment form as outlined in the home's policy. Staff #132 confirmed that the quarterly evaluation of the use of the PASD was not completed using the electronic assessment form. (561)

The home was not complying with their "Personal Assistance Service Devices (PASD's)" minimizing restraining policy. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that their written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 was offered a between-meal beverage in the afternoon on a specific day in January, 2016. The resident had a labeled snack; however, the resident was not offered a beverage in addition to the snack. The Registered Dietitian confirmed that staff should have offered the resident a beverage in addition to the snack. The resident's plan of care directed staff to offer a glass of fluid every two hours. The resident was at high nutrition risk with a history of significant and progressive weight loss. [s. 71. (3) (b)]

2. The licensee failed to ensure that all residents were offered a snack in the afternoon of January, 2016.

Not all residents were offered a snack in addition to a beverage at the observed afternoon snack pass. Residents who required a nutritional supplement at the afternoon snack pass received the supplement; however, were not offered a food snack in addition

to the nutritional supplement (beverage). The Registered Dietitian confirmed that residents were to be offered the regular snack in addition to the labeled supplements. Seven out of 13 (54%) residents observed were not offered a snack in addition to a beverage (residents #056, 053, 075, 076, 054, 004, 078). Staff #162 and #131 serving the snack cart in January, 2016, confirmed that not all residents were offered a snack in addition to a beverage. Staff #131 stated that the snacks were only provided to residents who could chew well, despite soft snacks and pureed texture being available on the snack cart. Staff #162 did not have a reason for some residents not being offered a snack in addition to a beverage. [s. 71. (3) (c)]

3. The licensee did not ensure that the planned menu items were offered and available at the observed lunch meals over a two day period in January, 2016.

Mashed potatoes were substituted for pureed bread at the lunch meals on specific dates January, 2016. The Cook preparing meals stated that pureed bread was prepared on specific dates in January, 2016; however, was not offered to residents. The Registered Dietitian confirmed that staff were to follow the planned menu and mashed potatoes were not to be substituted for pureed bread. The substitution was not approved by the Registered Dietitian.

Resident #008 had a plan of care that stated mashed potatoes were not to be offered to the resident. At the observed lunch meals on specific dates in January, 2016, pureed bread was not offered to the resident as per the planned menu and the resident's plan of care directed staff to avoid mashed potatoes. The resident was offered different pureed foods on a specific day in January, 2016, and another type of pureed food the following day in January, 2016. The nutritive value of the meal was reduced when pureed bread was not offered. The resident was at high nutrition risk with a history of ongoing and significant weight loss. [s. 71. (4)]

4. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

Resident #007 was not offered the planned menu items at the observed lunch meal on a specific day in January, 2016. The resident came to the dining room late and sat at the table without receiving food for 15 minutes. The resident was not offered soup (as per the planned menu) and the Registered Nurse #132 confirmed the resident enjoyed soup and would often only consume soup and a beverage at the lunch meal. The resident was provided a meal and was not asked their preference between both menu choices for the

entree and dessert. The resident was at moderate nutrition risk. Resident #006 was not offered dessert (as per the planned menu) at the observed lunch meal on a specific day in January, 2016. Staff stated the resident was not offered dessert as they required a blenderized menu. Instructions related to the type of fluids to add for different desserts for a blenderized menu were available at the servery. Progress notes identified the resident enjoyed sweet items and dessert. The resident was not offered all items as per the planned menu resulting in reduced nutritive value of the meal. The resident had a history of ongoing and significant weight loss and was at high nutrition risk. (107) [s. 71. (4)]

5. The licensee failed to ensure that the planned menu items were offered and available at the afternoon snack pass on two specific days in January, 2016. The planned snack menu for one of the dates in January, 2016, for residents receiving a Modified Diabetic menu or texture modified menu (minced and pureed) required digestive cookies to be offered and on the following day, the snack menu required shortbread cookies. Social Tea cookies were offered at the afternoon snack on both days, resulting in a reduced variety of items being offered to residents requiring those diets. The Dietary Aide #117 was preparing snacks on a specific day in January, 2016, stated shortbread cookies were not available. The Nutrition Manager confirmed that Shortbread cookies and Digestive cookies had not been ordered and were not available for the snack carts on those days. (107) [s. 71. (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 each resident is offered a minimum of,
(i) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner;
(ii) a snack in the afternoon and evening; and
(iii) to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #10: 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,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that menu substitutions were comparable to the planned menu.

The planned pureed menu for a specific date in January, 2016, identified residents receiving a pureed menu were to be offered pureed bread with the meal. The Dietary Aide #113 serving the observed lunch meal on that day, confirmed that pureed bread was not prepared and available as per the planned menu and that mashed potatoes and gravy were substituted for the pureed bread. Mashed potatoes were not a comparable substitution for pureed bread (different food group, less fibre, different nutrient profile). The Registered Dietitian confirmed that staff were to follow the planned menu and mashed potatoes were not to be substituted for pureed bread. The substitution was not approved by the Registered Dietitian. [s. 72. (2) (e)]

2. The licensee failed to ensure that all food and fluids were stored and served using methods that prevented food borne-illness at the lunch meal on a specific date in January, 2016.

Dietary staff portioned a meal for two residents who were not eating the meals right away. The plates were covered in saran wrap with the two residents' names (#004, #053) on the saran wrap and the plates were left sitting on the top of the hot plate (hot plate was turned off). The meals were still sitting at room temperature at 1415 hours and the temperatures of the foods had not been maintained as the food was not refrigerated or hot held. Pureed fish was probed at 86.3 degrees Fahrenheit (F); mashed potatoes and gravy 89.9 degrees F, creamy coleslaw 87 degrees F, and regular texture fish sticks 86.1 degrees F. The plates were still there at 1515 hours. Registered staff #132 stated that

the meals were being saved for the residents as resident #053 did not wake up until lunch time and resident #004 did not want their meal at lunch time.

The home's policy, "Food Temperatures NFS 03-02-50", revised July 31, 2015, directed staff to store foods at 4 degrees Celsius (C) or 40 degrees (F) for refrigerated foods, and that foods held for service were to be maintained at safe temperatures between 145 degrees F to 190 degrees F depending on the food item. The Nutrition Manager confirmed that staff were not leave foods at room temperature if meals were being saved for residents. [s. 72. (3) (b)]

3. The licensee failed to ensure that all food and fluids were stored and served using methods that prevented food borne-illness at the lunch meal on a specific date in January, 2016.

Dietary staff portioned a meal for two residents who were not eating the meals right away. The plates were covered in saran wrap with the two residents' names (#004, #053) on the saran wrap and the plates were left sitting on the top of the hot plate (hot plate was turned off). The meals were still sitting at room temperature at 1415 hours and the temperatures of the foods had not been maintained as the food was not refrigerated or hot held. Pureed fish was probed at 86.3 degrees Fahrenheit (F); mashed potatoes and gravy 89.9 degrees F, creamy coleslaw 87 degrees F, and regular texture fish sticks 86.1 degrees F.

The plates were still there at 1515 hours. Registered staff #132 stated that the meals were being saved for the residents as resident #053 did not wake up until lunch time and resident #004 did not want their meal at lunch time.

The home's policy, "Food Temperatures NFS 03-02-50", revised July 31, 2015, directed staff to store foods at 4 degrees Celsius (C) or 40 degrees (F) for refrigerated foods, and that foods held for service were to be maintained at safe temperatures between 145 degrees F to 190 degrees F depending on the food item.

The Nutrition Manager confirmed that staff were not leave foods at room temperature if meals were being saved for residents. [s. 72. (3) (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 menu substitutions are comparable to the planned menu, to be implemented voluntarily.

WN #11: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist resident #008 with eating at the observed lunch meals on two specific dates in January, 2016. The resident had a plan of care that included specific feeding strategies as recommended by the Speech Language Pathologist (SLP). The staff assisting the resident used a full spoon of food and the resident was unable to open their mouth wide enough for the full amount of food. The resident was at high nutrition risk. The Registered Dietitian confirmed that the resident required 1/4 teaspoon portions when being assisted with eating. [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #12: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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).

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. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee did not ensure that procedures were developed and implemented for cleaning of the home, specifically resident bedroom and dining room floors, dining room chairs and walls.

A) On three specific dates in January, 2016, the dining room walls in all 5 home areas were observed to be soiled. Specifically in areas where the food waste carts were parked

against walls, around garbage containers, water coolers, under and beside servery pass through windows, on posts and servery doors. Dining room chairs were observed to have soiled frames and stained seats in the Rosewood (12 chairs), Garden Path (5 chairs) and Daisy Drive (9 in chairs) dining rooms. According to the Food Safety Manager, the dietary aides did not clean the chairs or the walls between meals. According to the Housekeeping Supervisor, who was a contracted employee, the walls were to be cleaned once per month and chairs were cleaned once per week. The Environmental Services Supervisor reported that seats were steam cleaned possibly once per month. The cleaning policies were reviewed which were developed by the contracted housekeeping service and the policies directed housekeeping staff to clean dining room chairs once per week and that the walls were to be cleaned daily to "high hand level". No policy was developed to ensure that the chairs would be cleaned when they become soiled and the wall cleaning procedure was not being implemented.

B) The walls were visibly soiled in certain resident bathrooms in two specific dates in January, 2016. According to the contracted service provider's policies, walls in resident bathrooms were not included in the daily cleaning routine of resident bathrooms and were only listed on the daily cleaning routine for resident bedrooms which stated that they were to be spot cleaned as required. The procedures were not clearly developed.

C) The flooring material in the resident rooms and 4 out of 5 dining rooms was comprised of a rubberized sheet vinyl that was textured to resemble a wood floor. The texture of the floor included many groves and crevices which trapped dirt. Without the use of a bristle pad, the dirt could not be removed by normal mopping as was observed. All 4 dining rooms were observed to have trapped dirt in these grooves and a build-up was notably evident around the perimeter of the 4 dining rooms. According to the housekeeping supervisor, the floors were stripped and waxed once per year, regardless if the flooring material was made for wax or not. She reported that the wax kept the dirt out of the grooves and reduced the appearance of scratches. The housekeeping policies directed staff to "spray buff vinyl dining room floors once per week" and that resident room floors would be buffed and waxed when necessary. The housekeeping supervisor confirmed that this task and frequency was not being implemented due to a lack of staffing. The buffing machine included a bristle pad to help remove ground in dirt. The home was confirmed to have flooring material only in corridors, which required regular waxing and buffing. The sheet flooring was not designed to be waxed according to the manufacturer and could damage the floor. The contracted service policies and procedures were not developed for the home specifically, which included tasks geared to the various types of flooring material in the home and the necessary cleaning routines essential to keep the

floor from dirt build-up. [s. 87. (2) (a)]

2. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were developed and implemented for, cleaning and disinfection of contact surfaces in accordance with manufacturer's specifications.

Resident #037 and #039 had air mattresses on their beds related to being high risk for pressure ulcers and skin breakdown. Both resident rooms were also observed over a five day period in January, 2016 as having lingering offensive odours. Staff #100, #144 and #145 were unable to locate the manufacturer instructions for cleaning the air mattresses in both resident rooms, and were unsure where to find them. The DOC and staff confirmed the home had no procedures developed and implemented in accordance with the manufacturer specifications for cleaning and disinfection of contact surfaces. [s. 87. (2) (b)]

3. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the Resident Quality Inspection (RQI) the following resident rooms on the Rosewood Unit had lingering offensive odours in three resident rooms. The lingering odours were identified over a five day period in January, 2016. The home's Environmental Services policies and procedures were reviewed, and the LTC Inspector was unable to locate a procedure for addressing lingering offensive odours. Staff #103 and #123 were interviewed and they were unable to identify a procedure for addressing offensive odours. Staff #123 was unable to identify what procedures they would implement in resident rooms to address the odours. Staff #123 confirmed the home had no policy or procedure implemented for addressing incidents of lingering offensive odours. [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 were developed and implemented for cleaning of the home, specifically resident bedroom and dining room floors, dining room chairs and walls, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).**

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee did not ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance, specifically related to the condition of the flooring material.

A) On a specific date in January, 2016, the flooring material was observed to be in poor condition in five resident washrooms. The flooring material was either split by the front or back of the toilet and/or had shrunk away from the walls. The flooring material in two other rooms had lifted and bubbled up, creating a potential trip hazard. The flooring material in the bedroom of another room was observed to have curled away from one wall along the entire length. The Administrator had not been made aware of the condition

of the flooring and a schedule was therefore not put into place to repair the flooring.

With respect to the home's preventive maintenance schedules, the licensee's policy XX111-E-30-10 titled "Resident Room Deficiency Audit" required that maintenance staff complete a room audit once every 6 months for the condition of many different surfaces in resident rooms. According to the Administrator, the audits had not been completed in 2015.

B) The dining room on one of the units had a split in the floor at a seam by one of the resident tables on a specific date in January, 2016. Two days later, the seam was covered with duct tape. No scheduled repair was planned for this floor. [s. 90. (1) (b)]

2. The licensee did not ensure that procedures were implemented to ensure that all equipment, specifically lift slings were kept in good repair.

Mechanical lifts and associated slings were noted to be in use in the home at the time of inspection. One sling in particular was observed to be in very bad condition and was found to be on a floor lift which was parked in a tub room located on one of the resident units. The sling had loose stitching in many places on the sling and approximately 5 inches of the waistband padding had come apart from the rest of the sling. The sling also had a partially worn tag and was difficult to see all of the information on the tag. A sling found in the Lilly Lane tub room was also noted to have loose stitching and a worn out tag.

The licensee developed several procedures (VII-G-20.50 and 20.50(a) – "Sling Laundering" and "Care of Mechanical Lift Slings) which directed staff to "perform the pre-use sling integrity check as per policy" and "remove from use any sling showing signs of wear and tear (i. rips, fraying, tears) and to notify registered staff on the home area". Only one tub room out of 5 had a laminated yellow sign hanging from a peg on the wall near the tub that was titled "How to conduct a sling Integrity check". The sign instructed that slings be checked for any rips or holes, worn labels and loose stitching. Once the check was completed, the findings were to be documented on the "Sling Inventory Sheet" [IX-F-10.50(a)] and returned to the Director of Care.

The Director of Care was not able to provide the form for review as she was not aware of it and was therefore not monitoring the process. The staff using the identified sling located on one of the home areas were not completing an integrity inspection as required and the policy was therefore not implemented. All health care staff were given orientation

when hired regarding the expectations of checking the slings. According to the Director of Care, new slings had been purchased in December, 2015 and were in the home to be distributed, but because they were of a different style and manufacturer, staff had not been instructed as to their use at the time of inspection. [s. 90. (2) (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 are schedules and procedures in place for routine, preventive and remedial maintenance, specifically related to the condition of flooring material, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. 1. The licensee failed to ensure that drugs were stored in an area or a medication cart, i. that was used exclusively for drugs and drug-related supplies.

During an observation of the medication pass on a specific date in January, 2016, on one of the resident units, the LTC Inspector found the following items in the narcotic bin in the

medication cart:
- jewellery,
- a wallet,
- coins,
- ziploc bags,
- few labels with residents' names and medications on them.

The RPN #109 indicated these items were stored in the bin for safe keeping. The home failed to ensure that drugs were stored in a medication cart that was exclusively used for drugs.

2. The licensee failed to ensure that drugs were stored in an area or a medication cart, iv. that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting)

On a specific date in January, 2016 the LTC Inspector found the following medications that were expired in the cabinet where government stock was being kept:
- 18 bottles of medication had expiration date of September, 2015
- 10 bottles of another type of medication with an expiry date of December, 2015

The DOC confirmed that these medications should have been disposed of. [s. 129. (1) (a)]

2. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On a specific date in January, 2016 one of the resident units, the LTC Inspector observed all controlled substances on blister cards stored in a regular drawer instead of the double locked bin in the bottom drawer of the medication cart. The RPN #109 confirmed that the narcotics should have been stored in a locked bin in the medication cart. The home failed to ensure that controlled substances were stored in a separate locked area within the medication cart. [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

The home's policy for "Personal Care - Hygiene and Grooming", policy number V3-212, and revised November 2015, directed staff to shave residents each day. The PSWs #106, #146 and #147 were interviewed and identified that they were expected to shave and groom residents daily. The ADOC #104 and #105 were interviewed and confirmed that staff were expected to provide residents with personal hygiene care and groomed daily. Resident #039 was observed over a five day period in January, 2016 unshaven. The resident was not interviewable. The home's policy and procedure also directed staff to refer to the text for shaving the client; however there was no text book in the home for the PSWs to reference. The resident did not receive individualized personal care related to shaving on a daily basis. [s. 32.]

WN #16: 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 the resident received fingernail care, including the cutting of fingernails.

The home's policy for "Personal Care - Hygiene and Grooming", policy number V3-212, and revised November 2015, directed staff to provide fingernail care to resident #033 when bathed twice weekly and whenever necessary. The PSWs #147 and #150 were interviewed and confirmed they were expected to provide fingernail care when the resident was bathed twice weekly, and to clean the resident's nails when necessary. The resident was observed over three days in January, 2016 with long fingernails and feces under their nails. The staff failed to ensure the resident received fingernail care. [s. 35. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #039 received end-of-life care when required in a manner that met their needs.

The home's policy and procedure called "Hygiene, Personal Care & Grooming", number VII-G-10.50 and revised January, 2015, directed staff to provide resident #039 with special mouth care at least every 4 hours as they were at end of life. The policy refers staff to a textbook for the oral care procedures; however there was no text book in the home. Resident #039 was observed over a five day period in January, 2016 with debris in their mouth, and their tongue was dry and coated. PSWs #106, #143 and #147 identified that they use the sponges for the resident's mouth care; however the LTC Inspector was unable to find any mouth care sponges at the residents bedside or in the bathroom. Staff were not observed providing mouth care at least every 4 hours as identified in the policy and procedure. PSWs #106 and #143 confirmed they were not performing special mouth care as outlined in their policy and procedure. The ADOC #104 was interviewed and confirmed that there was no text book in the building as referred to in the policy for oral care, and staff were expected to provide mouth care to the resident at least every four hours. Resident #039 required end of life care and their oral care needs were not met. [s. 42.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006, who was incontinent, received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Resident #006 had a plan of care that required staff to toilet the resident routinely and identified that the resident used a brief during and day/evening and at night related to incontinence. Registered staff #132 identified the resident had redness related to incontinence. The resident's plan of care was revised to include strategies for increased toileting; however, an assessment was not completed using a clinically appropriate assessment instrument specifically designed for the assessment of incontinence. The last continence assessment of the resident was completed in May, 2015. The ADOC #105 confirmed the resident due to increased incontinence, was exceeding the current number of briefs provided. The plan of care was revised to include increased toileting to reduce the number of briefs the resident was using and to try to improve the resident's skin integrity. The resident's family voiced concerns to the LTC Inspector about the resident's briefs not being sufficient to contain the resident and stated the resident was often wet when they came to visit. The ADOC #105 confirmed that a standardized assessment of the resident's continence should have been completed prior to the revision of the resident's plan of care. [s. 51. (2) (a)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

The Family Council advised the home of concerns based on their meeting minutes from May, August, and November, 2015. The concerns were not responded to in writing within ten days of the home being advised. The President of the Family Council confirmed they did not receive written responses to their concerns. The Administrator confirmed the home had not received the concerns from the Family Council, therefore there were no written responses provided to the Family Council within 10 days of receiving them. [s. 60. (2)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee failed to ensure they consulted with the Residents' Council at least every three months. The Administrator confirmed that for 2015 consultation with the Residents' Council did not occur at least every three months. Documentation in the Residents' Council Meeting Minutes did not reflect that the licensee consulted with the Council at least every three months. [s. 67.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 70. Dietary services
Every licensee of a long-term care home shall ensure that the dietary services component of the nutrition care and dietary services program includes,
(a) menu planning;
(b) food production;
(c) dining and snack service; and
(d) availability of supplies and equipment for food production and dining and snack service. O. Reg. 79/10, s. 70.

Findings/Faits saillants :

1. The licensee failed to ensure that the dietary services component of the nutrition care and dietary services program included availability of supplies and equipment for food production and dining and snack service.

At the observed third floor lunch meals on two specific dates in January, 2016, there was an insufficient quantity of dessert bowls resulting in pureed desserts being served on plates (pudding, pureed fruit cocktail, applesauce). Serving the pureed desserts on plates did not promote independence in eating (more difficult to scoop foods onto spoon from a plate). The Dietary Aide #113 confirmed that there were not enough bowls available. The Nutrition Manager stated they were unaware that there were insufficient dishes available and the issue had not been communicated to them prior to the lunch meal. [s. 70. (d)]

Issued on this 26th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), BERNADETTE SUSNIK (120), DARIA TRZOS (561), MICHELLE WARRENER (107), SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2016_431527_0001
Log No. / Registre no:	035413-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 25, 2016
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	LEISUREWORLD CAREGIVING CENTRE - BRAMPTON WOODS 9257 Goreway Drive, BRAMPTON, ON, L6P-0N5
	Adam Kertesz

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

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Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Administrator /
Nom de l'administratrice ou de l'administrateur :

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall ensure that the following are completed:

1. Amend the existing procedure titled "Specimens, Swabs and Laboratory Reports (IX-E-10.60) dated January 2015" to include the expectations for registered staff when results are positive for any type of infection (UTI, URI, Wound infection, Eye infection etc.), acceptable time frames for repeat samples, how to manage situations when residents have inadequate urine output, how to ensure urine samples are not contaminated (by contaminated gloves, urine hats, incorrect personal cleaning methods), when the use of an in\out catheter is warranted, how specimens are to collected if residents are not able to sit on a commode, proper storage of collected specimens and the proper storage of urine hats to avoid contamination, when the POA should be contacted and what form should be used to keep track of each resident who has had a laboratory culture taken and the results and follow up actions.

2. Develop a method to track all residents who are required to have a specimen collected and submitted or re-submitted to the laboratory for analysis. The method of tracking shall include at a minimum who took the culture and at what time, how and where the specimen was stored after collection, when it was picked up by the laboratory, when the result was received and actions taken after laboratory report received.

Grounds / Motifs :

1. The licensee failed to ensure that the organized program of nursing and personal support services required under section 8 of the Act, that the program included relevant procedures and protocols and provided methods to reduce risk and monitor outcomes specifically related to urinary tract infections.

The nursing services required residents' needs to be assessed and that unregulated care providers be supervised in carrying out activities related to personal hygiene, activities of daily living and other duties as delegated.

The home's policy "Specimens, Swabs and Laboratory Reports (IX-E-10.60) dated January 2015", directed registered staff to "take specimens and swabs according to proper procedure and using personal protective equipment and precautions as indicated". According to registered staff, proper urine sampling procedure was a routine process that they were required to know as part of their profession and procedures for taking various types of specimens and swabs were available in their laboratory forms provided by the laboratory. Delegation of

the task to personal support workers (PSWs) was identified to be common practice in the home and registered staff confirmed that on many occasions, PSWs collected urine samples from residents during their morning routines.

According to laboratory procedures for taking urine specimens for testing, instructions were provided. The RNs reported that they showed the PSWs how to take the samples but that there was no supervision thereafter. Formal training on urine collection procedures was not provided until September 2015 to the PSWs and registered staff.

A review of the home's urinary tract infection statistics between January and December 2015, revealed that a number of residents had urinary tract infections each month. No baseline calculations were available to determine if the numbers were overly high or average for the population base. In reviewing the progress notes for various residents who had positive bacterial growth in their urine specimens and were treated with antibiotics, collecting specimens and other challenges were reported by staff. Two residents in particular were identified as residents #055 and #006.

A) Between January and December 2015, resident #055 was being routinely monitored and had a number of samples collected, several samples were positive for bacterial growth. In two cases, the laboratory claimed that there was an error on their part and the samples were repeated. According to the progress notes made by registered staff throughout this period, numerous accounts were made as to the difficulty staff had acquiring a sample. Laboratory results that indicated high bacterial growth led to additional testing as well as two separate transfers to the hospital.

B) During the last three weeks in October to the beginning of November, 2015, resident #006 exhibited symptoms typical of an infection. Staff documented in the progress notes that they had difficulty obtaining a sample due to the resident's resistive behaviour or refusal, and the sample was not attempted for 3 days each time. An alternative strategy was used with better success. The resident was sent to hospital on later date in November, 2015 and was admitted.

The home's policy did not include relevant procedures and protocols and methods to reduce risk and monitor outcomes specifically related to certain infections. No strategies or direction was available or implemented to address resident behaviours, how to manage situations when residents had inadequate

output, how to ensure samples were not contaminated (by contaminated gloves, collection devices, incorrect cleaning methods), when the use of a catheter was warranted, how specimens were to be collected if residents were not able to sit on a commode, proper storage of collected specimens and the proper storage of collection devices to avoid contamination. The overall outcomes related to specific infections were difficult to determine as the home was not evaluating and analyzing their data. (120) [s. 30. (1) 1.]
(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

The licensee shall ensure that the following are completed:

1. Develop a process to evaluate personal protective equipment (gloves) in the home to ensure they meet quality standards and do not become a source of contamination if used for hygienic tasks.

2. Develop a process to ensure that the Infection Control Practitioner is involved in evaluating the disinfection products used in the home to ensure the products used are effective against the various pathogenic organisms encountered in the home.

3. Develop a process to evaluate the cleaning and disinfection practices in the home related to bed pans, wash basins, urinals, tubs, tub lift chairs and shower chairs and that the policies and procedures available to staff regarding these tasks are clear and established in accordance with "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, May 2013".

Grounds / Motifs :

1. 1. The infection prevention and control program did not include measures to prevent the transmission of infections.

A) The home did not have a supply of a sporicide available to disinfect touch point surfaces for instances when a bacterium known as C. difficile was being shed by residents. The bacteria is found in the gastrointestinal tract of

individuals who have been on antibiotics over a long period of time. The bacterium produces a toxin or spore which is not susceptible to low level disinfectants which are typically used in long term care homes. Two cases were confirmed to be present in the home between December, 2015 and January, 2016. A review of the various types of disinfectants in the home revealed that no sporicide was available for use by housekeeping staff. Two different products were being used, neither of which had information on the label or manufacturer's website that they were adequate for use against C. difficile. Both were general bactericides. The infection control designate was not aware of the issue and assumed that the contracted housekeeping service hired by the licensee was aware. The housekeeping supervisor was not aware of the difference between a sporicide and a bactericide and did not realize that C. difficile could not be eliminated by using a bactericide. Measures to ensure that staff were using the appropriate products for the target infection were not in place.

B) Various types of equipment and devices were not being cleaned and disinfected as required by the manufacturer or the home's equipment cleaning policies to reduce or prevent the transmission of infectious organisms.

i) The interior surface of tubs located in several home areas were observed to be dirty in appearance in January, 2016. A layer of soap scum and a black ring around the tub was evident and when scrubbed with a wet paper towel, the residue could be removed. According to the tub manufacturer and the home's tub cleaning protocols, the tubs were to be cleaned and disinfected between each use. The visible residue confirmed that this practice was not followed by the PSWs who bathed residents in the tubs. The continued use of dirty tubs placed residents at risk for the transmission of organisms that resided on the surfaces of the tub from resident to resident and would be re-introduced into the tub water once filled.

ii) The underside surface of tub lift seats located in several tub rooms were observed to have a moderate amount of residue, a combination of soap scum and bodily oils in January, 2016. On another date in January, 2016 the tub rooms on four units were inspected, and observed scum and residue on the bottom side of the tub lift seats. According to the tub lift seat manufacturer and the home's tub chair cleaning protocols, all sides of the tub chairs were to be cleaned and disinfected between each use. The visible residue confirmed that this practice was not being followed by the PSWs who bathed residents in the tub. The tub lift seat was designed to be lowered into the tub water while the

resident sat on the seat. The resident could be transferred into the bath water or remain seated on the set. The tub water, containing organisms from the residents' skin and orifices could easily adhere to the surfaces of the tub lift seat and sides of the tub after each bath and be re-introduced into the tub water for the next resident, transmitting potential pathogens.

iii) According to a document titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices, 2013", non-critical devices such as bed pans, wash basins and urinals are to be cleaned and disinfected with a low level disinfectant after each use (unless the device is not used by any other person whereby cleaning is sufficient). Two wash basins located in the washroom on the second floor, and one basin in washroom on the third floor were observed to have visible residues on them on several days in January, 2016. It was apparent that staff did not clean the basins after use or that PSWs were not monitoring the condition of the basins. No auditing or monitoring process was developed to ensure that personal care articles such as wash basins were being adequately cleaned and disinfected. According to the infection control designate, staff were required to wipe the basins out after use with a cloth or paper towel moistened with disinfectant (Virudex-7) and returned to a shelf under the vanity in the resident's bathroom. The Virudex-7 bottles were to be acquired from either the tub or shower rooms.

According to the home's policy for cleaning and disinfecting nursing supplies (V6 -030), the wash basins were required to be cleaned in the soiled utility room using "germicidal disinfectant". When all five soiled utility rooms were observed, they were equipped with Virudex-7 disinfectant that had expired in November, 2014. They were located under cleaning sinks and were hooked up to dispensing systems which could dilute the chemical with water for the purposes of cleaning and disinfecting wash basins. However, based on staff information, basins were rarely cleaned in soiled utility rooms. The PSWs reported using the tub disinfectant or the bottles of Virudex-7 located in the shower rooms. The policy did not identify where exactly in the soiled utility room to clean the items (a hopper and large sink were available), if any brushes were to be used, how the dispensing system was to be used, how long the disinfectant was to remain on the items, whether the items needed to be rinsed after wards and how the item would be kept clean during storage. There appeared to be some confusion as to the process between the expectations and the written procedures developed. Without clear expectations for staff to follow and routine monitoring, devices such as bed pans and wash basins act as vehicles for the transmission of

organisms, from one body area to another (in the case when wash basins used for bed baths) and from staff hands to other surfaces when not adequately cleaned and disinfected when necessary. Measures were not in place to monitor the cleaning and disinfection practices of staff to ensure that equipment and devices were adequately cleaned and disinfected.

C) According to the Provincial Infectious Diseases Advisory Committee document titled "Routine Practices and Additional Precautions in all Health Care Settings, 2012 (p.28)" the "indiscriminate or inappropriate use of gloves has been linked to the transmission of pathogens". During the inspection, boxes of disposable gloves could not be found other than on the medical carts of registered staff. The glove type was noted to be a non-sterile exam glove. When PSWs were asked where they obtained their gloves, they reported that they kept them in their uniform pockets. Further probing revealed that the PSWs each received a box or two once per month and that their boxes of gloves were then taken to their lockers or to their home. Confirmation of this practice was made by registered staff and the Director of Care. Discussion was held regarding the high potential for the gloves to become contaminated before use and whether or not the type of glove was appropriate for the task. As best practices advises staff to wash their hands or use alcohol based hand rub before donning gloves in order to prevent the gloves from becoming contaminated, then the expectation is that the gloves be stored in a manner to prevent their contamination.

Practices that could lead to the transmission of infections in the home using contaminated gloves worn by PSWs included but were not limited to cleaning residents prior to acquiring urine and stool samples for culture, applying creams to the skin and assisting residents with oral hygiene. Measures were not in place to evaluate the storage practices of gloves and how the gloves were being used by staff and whether the type of glove being used was appropriate for the task. (120) [s. 86. (2) (b)]

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2016

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee shall ensure that the following are completed:

1. Provide training to all registered staff so that they understand how to complete the infection line listing on each shift in accordance with "Best Practices for Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011".

2. The Infection Control Designate (ICP) shall review the infection line listing from each home area on a daily basis and review the symptoms documented to determine any unusual trends or a clustering of cases in accordance with "Best Practices for Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011".

3. The ICP shall determine if the symptoms are related to a defined infection type identified in the "Best Practices for Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011" and implement treatment protocols and control measures to reduce or mitigate the spread of the infection.

4. The ICP shall gather the required infection data and calculate and analyze surveillance rates and evaluate preventive interventions in accordance with "Best Practices for Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011".

Grounds / Motifs :

1. 1. The licensee did not ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with prevailing practices and that the symptoms were recorded.

A) Prevailing practices identified in a document titled "Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2011" developed by the Provincial Infection Diseases Advisory Committee specifies that the onset date, resolve date, actions taken and symptoms of infection, are to be monitored and documented or recorded. The methods of monitoring and documentation may vary, however the licensee developed a policy IX-E-10.40 titled "Line Listing – Resident Surveillance" and form tilted "Infection control surveillance record" for use by registered staff to record the information as required in order to visually monitor the list for other residents with the same symptoms over the course of a specified time period. During the inspection, the licensee was not using the same form as outlined in their policy but was using a similar form titled "infection line listing". When reviewed for the month of January 2015, the line listings for each home area did not include any residents with symptoms of infections. The symptoms of infections were recorded electronically in individual resident progress notes which were not an ideal method of recording as it does not easily allow staff to monitor what trends or patterns were developing within one home area or throughout the home. The failure to adequately monitor resident symptoms from shift to shift and day to day could lead to outbreaks involving a large number of residents in a short period of time.

In January, 2015, an outbreak was declared by the local public health unit after receiving information from the licensee that residents had symptoms of an infection. By the end of January, 2015, there were cases on every home area. Manual and electronic line listings for the month of January, 2015 were reviewed; however the manual and original infection line listings for several units could not be located by the Infection Control Designate (ICD). According to the ICD, the hand completed forms were subsequently entered into an electronic data base by a designated person at the end of the month. The electronic forms included data from all home areas. Neither of the manual documents or electronic documents included any residents on the infection line list or surveillance record with any infectious symptoms. A separate infection line listing for public health was established, but only after a number of cases were identified and was subsequently used to continue monitoring resident cases.

A review of the progress notes was completed for a number of residents who were identified by registered staff to have had symptoms. Resident #049, #050 and #079 were sick on a specific date in January, 2015. Residents #020, #080, #081 and #025 were sick on a specific date in January, 2015. Resident #081 sat with their spouse #082 in a different dining room on a specific day in January, 2015 and was sick in the dining room. Resident #082 became unwell in January, 2015. None of these residents had their symptoms documented on the infection line listing.

B) Residents who were observed to have contact precaution signage on their room doors during January, 2016 were not all recorded on the "infection line listing". Some home areas had an "antibiotic line listing and a "pressure ulcer line listing" located in the RNs binder. The documentation of infections on other forms was not specified in the home's infection prevention and control policies. Only one home area started an infection line listing by mid-January, 2016. A review of the residents' charts confirmed that the residents noted below were on contact precautions for antibiotic resistant organisms and were not captured on the appropriate line listing or any other listing kept by the RN in each home area.

Out of 9 residents on contact precautions, only 3 (#062, #083 and #084) out of the 9 residents were recorded on the January infection line list, and 5 (#022, #062, #063, #084, and #085) out of the 9 were recorded on the December infection line list.

The above residents and any others who were confirmed with a positive culture for any antibiotic resistant organisms would be required to be added to the infection line list and carried over from month to month until their infections were resolved. [s. 229. (5) (b)]

2. The licensee did not ensure that the information gathered under subsection 5 (symptoms of infection collected on each shift) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

The infection control designate was not able to provide any trends or infection rates from any particular surveillance period (day to day, month to month or year to year) for their infections in the home. The rates of infection were not

calculated (per 1000 resident days) to establish a baseline of frequency and type of infection expected for the resident population base in the home. The data that was gathered on infection line listings for each home area listed only the total number of each type of infection. In some cases, symptoms of infection were not included on the line listing and were only found recorded in the resident progress notes. The data did not reveal whether the number of residents with clinical signs and symptoms of infection were reasonable over the course of an established surveillance period as no established internal or external benchmarks had been developed.

The home's policies titled "Line Listing - Resident Surveillance" originally dated June 2006, "Surveillance & Process of Data Collection" originally dated March 1997, and "Monthly Infection Control Summary Record" originally dated March 2002 and all revised January 2015 required that infection data be collected daily and analyzed daily and on a monthly basis to determine the incidence and prevalence of infections in the home. (120) [s. 229. (6)]

(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Hamilton Service Area Office