Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2014	2014_159178_0016	T-61-14	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 - O'CONNOR COURT
1800 O'Connor Drive, East York, ON, M4A-1W7

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

SUSAN LUI (178), JOELLE TAILLEFER (211), SUSAN SEMEREDY (501)

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): June 16, 17, 18, 19, 20, 23, 24, 25, 27, July 4, 2014.

The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI):
T-222-13 and T-722-14.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Nursing (DON), Associate Directors of Nursing (ADON), Resident Assessment Instrument (RAI) Coordinator, Director of Resident Programs, Resident Relations Coordinator (RCC), Director of Dietary Services (DDS), Registered Dietitian (RD), Environmental Service Manager (ESM), registered staff, personal support workers (PSWs), activation aides, physiotherapist, physiotherapy assistant, maintenance staff, residents, family members of residents.

During the course of the inspection, the inspector(s) observed residents' care, observed home environment including resident care areas, reviewed residents' records, reviewed the home's records.

The following Inspection Protocols were used during this inspection:

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

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On an identified day, the inspector observed an identified registered staff member administrating medication to resident #877 within the resident's room, using certain, but not all, infection prevention and control precautions needed for this resident.

A sign on the resident's door indicated that certain additional infection prevention and control precautions should be used when providing care to this resident, but did not

include all the necessary precautions required for a resident with this particular health condition. The resident's plan of care and the sign on the resident's door did not clearly indicate to staff or others providing care, the proper infection prevention and control precautions to be used when providing care to this resident.

Interview with an identified registered staff member and the Associate Director of Care confirmed that the resident's health condition required additional infection prevention and control precautions be used, which were not listed on the plan of care or on the door signage.

Four days later, the inspector observed that all the necessary infection prevention and control precautions were included on the signage on resident #877's door.

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review revealed that resident #919 began having altered skin integrity on April 19, 2014. On April 19, 2014, it was documented a stage one pressure ulcer identified on the resident's left hip and on May 10, 2014, a stage two pressure ulcer on the coccyx. Record review and interview with the registered dietitian (RD) confirmed that a nutritional assessment was completed on May 16, 2014, for weight gain, and that the RD was not made aware of the resident's altered skin integrity at that time. As a result, the nutritional supplement was discontinued. Record review and staff interviews revealed that a referral was later sent by registered staff to the RD on May 23, 2014, regarding altered skin integrity, with a suggestion to reorder a supplement. It was after this subsequent dietary assessment that the RD implemented a different nutritional supplement. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
On June 16, 2014, the inspector observed that resident #21 was served minced ham as part of his/her lunch entrée. Record review revealed that resident #21 is on a pureed textured diet. Interview with the dietary aide revealed that he/she ran out of pureed ham, asked for more to be brought up and then served what was brought up. Interview with the Director of Dietary Services revealed that this food item was of a minced texture and should not have been served to this resident. [s. 6. (7)]

4. The licensee has failed to ensure that the resident's plan of care is reviewed and revised when care set out in the plan of care is ineffective.
Staff interviews and record review confirm that resident #967's plan of care was not reviewed and revised when care set out in the plan was not effective.
Staff interview and record review confirm that resident #967 was assessed to have mood problems related to the disease process, as evidenced by the resident being depressed and sad. Care was planned for this problem and interventions were put into place on the resident's care plan.
The resident's Depression Rating Scale assessment scores were as follows:
August 1, 2013 was 2 out of 14.
October 18, 2013 was 1 out of 14.
January 10, 2014 was 7 out of 14.
March 31, 2014 was 11 out of 14.
Staff interviews and record review confirm that a score greater than 3 out of 14 indicates a possible depression.
Staff interviews and record review confirm that there was no change made to the resident's plan of care for mood during the period between August 1, 2013 and March 31, 2014, when the resident's depression score rose from 2 to 11 out of a possible 14.
[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 to ensure that:
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
-staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other
-the resident's substitute decision-maker (SDM) is given an opportunity to participate fully in the development and implementation of the resident's plan of care
-the care set out in the plan of care is provided to the resident as specified in the plan
-the resident's plan of care is reviewed and revised when care set out in the plan of care is ineffective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

On several occasions between June 16 and 17, 2014, the inspector observed that the door to the heat pump room located in the multi program room on the 2nd floor, was unlocked. Interview with an identified PSW and the environmental service manager confirmed that the lock on the door to the heat pump furnace door was broken and that this could pose a safety risk for the residents. On the afternoon of June 17, 2014, the inspector observed that the lock on the door to the heat pump room had been repaired and was found to be locked. [s. 9. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

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

On June 17 and 20, 2014, the inspector observed that the toilet tank in an identified resident's bathroom was missing its cover.

Interview with an identified maintenance staff member on June 20, 2014, confirmed that the toilet tank cover was missing and that no referral had been received by the maintenance department regarding the toilet tank cover.
The toilet tank cover was replaced the same day.

On June 17, 2014, inspector #596 observed that several tiles were broken in the north shower room on the first floor. On June 20, 2014, inspector #211 and an identified maintenance staff observed several broken tiles at the edge of the lower part of front shower wall.
The Environmental Service Manager (ESM) confirmed that he/she was aware of the broken tiles and was in the process of making arrangements to have the tiles repaired. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.
Resident interview, staff interview and record review confirms that resident #854 stated that he/she was handled roughly and yelled at by a member of the staff of the home. The resident reported the abuse to a MOHLTC inspector during an interview, and confirmed the allegation when he/she was interviewed by the home's management staff. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting residents.

Record review indicates that while being transported to the shower room via a shower chair on May 13, 2014, resident #877 fell forward and out of the chair. The resident sustained bruising of the left ankle and great toe, and was transported to hospital for assessment. No fractures were identified.

Interview with an identified PSW revealed that the entrance to the shower room has a small incline and the shower chair tilted forward while pushing it. The identified PSW confirmed that the transfer was unsafe because he/she was alone while pushing the shower chair, with no second staff member present as required by the home's policy # V3-850 revised March 2012, and by resident #877's written plan of care on April 2014. [s. 36.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, specifically a pressure ulcer, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review indicated that resident #919 exhibited a stage two pressure ulcer to the coccyx area on May 10, 2014. Record review confirms that the stage two pressure ulcer to the coccyx area was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
Interview with an identified registered staff member and the Associate Director of Care confirmed that the coccyx wound was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered staff, if clinically indicated.

Record review indicated that resident #919 exhibited a stage one pressure ulcer to the left hip on April 19, 2014 and a stage two pressure ulcer to the coccyx area on May 10, 2014.
Record review indicated that the stage one pressure ulcer on the left hip was not assessed weekly from April 19, 2014 to June 19, 2014.
Record review indicated that the stage two pressure ulcer to the coccyx area was not assessed weekly from May 10, 2014 to June 6, 2014.

Interview with an identified registered staff member and the Associate Director of Care confirmed that the wounds were not assessed at least weekly from April 19, 2014 to June 19, 2014 for the left hip wound and from May 10, 2014 to June 6, 2014 for the coccyx wound. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity:
-receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
-is reassessed at least weekly by a member of the registered staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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 planned menu items are offered and available at each meal.

The home's policy #V9-305 titled Mealservice-Eating Assistance Protocol for Residents Requiring Total Assistance at Meals and Snacks, revised February 2013, states that meal service choices should be offered visually via sample plates.

Interview with a family member revealed that residents on pureed diets do not receive a choice at meals. On June 23, 2014, the inspector observed during lunch on the third floor that six residents on pureed and minced diets were not offered a choice of entrée, and another resident who was on a pureed diet was not offered a choice of dessert. The inspector also observed on the same date that resident #937 who was being fed in bed was not offered two choices of lunch. Interviews with the Director of Dietary Services (DDS) and the RD confirmed that all residents should be offered choices of planned menu items.

On June 16, 2014, the inspector observed that resident #937 who was being served lunch in his/her room was not offered any dessert. Record review revealed that blueberries or strawberry frozen yogurt were the planned dessert options. Interview with the identified PSW serving the resident revealed that he/she did not offer this resident dessert because the dietary aide did not include dessert on the tray when it was prepared. The PSW serving the resident stated that he/she assumed that the home had run out of dessert. Interview with the DDS confirmed that resident #937 should have been offered dessert.

On June 16, 2014, the inspector observed that residents who refused soup were not offered juice during the lunch meal. Record review revealed that the planned menu indicated that a choice of either vegetable soup or 5 citrus juice be offered. Interview with the DDS confirmed that those residents who refused the soup option should have been offered juice. [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 planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #8: 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).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques are used to assist residents with eating.

The home's policy #V9-305 titled Mealservice-Eating Assistance Protocol for Residents Requiring Total Assistance at Meals and Snacks, revised February 2013, states that the individual providing assistance for residents should be sitting at eye level and staff should be at eye level when providing eating assistance for residents in bed.

On June 16, 2014, the inspector observed a PSW standing while assisting resident #23 with drinking during the lunch meal. Interview with the DDS confirmed that staff should be seated and at eye level with the resident when assisting residents with eating and drinking.

On the same day, the inspector observed another PSW standing while feeding resident #937 in bed. The PSW was not at eye level with the resident and the resident was facing the other direction while being fed. Interview with the DDS confirmed that staff should be at eye level and facing the resident when feeding. [s. 73. (1) 10.]

2. The licensee failed to ensure that residents who require assistance with eating are only served a meal when someone is available to provide assistance.
On June 16, 2014, the inspector observed that resident #23, whose plan of care states he/she requires total assistance with meals, was served a lunch entrée and not offered assistance until 10 minutes later. Interview with the DDS confirmed that residents should be assisted with eating as soon as the meal is provided. [s. 73. (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 proper techniques are used to assist residents with eating and that residents who require assistance with eating are only served a meal when someone is available to provide assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council and Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the meeting minutes of the Family Council and Residents' Council indicated no discussion took place regarding the latest satisfaction survey. Interviews with family, resident, and staff confirmed that the home used a quality improvement program for the latest satisfaction survey and the Family and Residents' Councils were not consulted or given the results of the survey. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the advice of the Family Council and Residents' Council is sought in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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. The licensee failed to ensure that procedures are developed and implemented to make sure all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

Observations made on June 17, 2014 confirmed that toilet grab bars were found to be loose and unstable in three identified residents' washrooms.
Maintenance staff agreed that the above identified toilet grab bars were unstable and required replacement or repair. Subsequent observations on June 20, 2014, confirmed that the grab bars in the identified residents' bathrooms were either repaired or replaced, except in the case of one resident's bathroom where the toilet was not used by a resident, so the grab rails were removed altogether. [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 procedures are developed and implemented to make sure all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention program.

On June 23, 2014 at approximately noon, inspector #178 observed an identified staff member administering medications to two different residents without performing hand hygiene in between the tasks.
The inspector observed the staff member don gloves before administering insulin to a resident. The staff member did not perform hand hygiene before donning or after doffing the gloves. The staff member proceeded to administer an oral medication to this resident, then administered an oral medication to another resident without performing hand hygiene in between the tasks. [s. 229. (4)]

2. On June 17, 2014, inspector #587 observed that two commode pails were placed on the floor of the first floor shower room.

On June 20, 2014, inspector #211 again observed the two commode pails were left on the floor in the shower room.

Interview with the associate director of care confirmed that the commode pails should be stored under the shower chair, but not on the floor, to prevent the possible transmission of infection. [s. 229. (4)]

3. The licensee failed to ensure that staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices.

Review of employment records for three recently hired staff members confirmed that none of the three were screened for tuberculosis in accordance with evidence-based practices, or in accordance with the home's policy. None of the three staff members were screened for tuberculosis within 6 months prior to the employees starting work in the home, or within 14 days after starting work in the home. All three employees had been hired within the past year.

The home's policy titled Tuberculosis Screening Requirements for Staff, policy number V6-310.10, last reviewed May 2014, indicates that a tuberculosis screening for all new staff must be initiated within six months before starting work or within 14 days of starting work.

Two of the surveyed staff members had no record of tuberculosis screening at all. The third staff member was screened for tuberculosis more than two months after starting work in the home.

Interview with the unit scheduling coordinator confirmed that he/she did not have the tuberculin result of two staff and that one staff started working prior receiving the result. Interview with the home's administrator confirmed that it is the home's policy and usual practice to screen new staff for tuberculosis within two weeks of hire, unless they have already been screened within six months before hire. [s. 229. (10) 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:
-all staff participate in the implementation of the infection prevention and control program
-staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing is provided to the Residents' Council within 10 days of being advised of concerns or recommendations.

Review of the Residents' Council meeting minutes revealed that in February 2014, a concern was raised that the tablecloths in the dining rooms were soiled. Interviews and record review confirmed that this concern was not responded to in writing within 10 days, and has not yet been resolved. [s. 57. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all fluids are served using methods which prevent contamination.

On March 16, 2014, the inspector observed on the third floor a PSW taking a tray to an identified resident's room without covering the beverages. On the same date, inspector #587 also observed a tray being taken to a resident's room on the first floor without the beverages and soup covered. Interview with the DDS confirmed that these beverages and soup should have been covered to prevent contamination. [s. 72. (3) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who received the training required by section 76(2) of the Long Term Care Homes Act (LTCHA), specifically training about the duty to make mandatory reports under section 24 of the Act, and the whistle-blowing protections provided under the Act, prior to performing their responsibilities, have received retraining annually as required by this subsection.

Record review and staff interviews confirm that in 2013 not all staff were retrained relating to the duty to make mandatory reports under section 24, and the whistle-blowing protections offered under the LTCHA. The home provided written material regarding residents' rights and abuse to all staff, and required that the staff read the material, complete the quiz and sign a testimonial indicating they had done so. However the material provided to all staff did not include an accurate explanation of the duty to make mandatory reports under section 24 of the LTCHA. Nor did it include a description of the whistle blowing protections offered under the Act for persons who disclose information to an inspector or to the Director under the LTCHA.

The home did provide an in-service which addressed the duty to make mandatory reports under section 24, however this in-service was attended by only 56 out of 168 staff in 2013. The in-service material did not address the whistle-blowing protections offered under the LTCHA for persons who disclose information to an inspector. [s. 76. (4)]

WN #15: 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. The licensee has failed to ensure that drugs are stored in an area that complies with manufacturer's instructions for the storage of the drugs, specifically in a refrigerator.
Observation and staff interviews confirm that an identified registered staff member failed to store an identified medication in a refrigerated space as directed by the home's pharmacy. [s. 129. (1) (a)]

Issued on this 23rd day of July, 2014

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

Susan Sui (178)