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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 3, 2015	2014_251512_0023	T-079-14	Resident Quality Inspection

Licensee/Titulaire de permis

NORWOOD NURSING HOME LIMITED
122 TYNDALL AVENUE TORONTO ON M6K 2E2

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

NORWOOD NURSING HOME
122 TYNDALL AVENUE TORONTO ON M6K 2E2

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

TILDA HUI (512), JOANNE ZAHUR (589), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 16, 17, 18, 22, 23, 24, 29, 30, 31, 2014, January 2, and 5, 2015.

Additional inspection related to the following log number was also completed during this inspection:
1) T-761-13, Complaint.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), registered nurses (RN), registered practical nurses (RPN), resident services coordinator, dietary director, maintenance manager, registered dietitian (RD), physiotherapist (PT), personal support workers (PSW), cook, dietary aide, laundry aide, residents, family members and substitute decision makers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

14 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 and free from neglect by the licensee or staff in the home.

Interview with resident #003 indicated an incident which occurred on an identified date at an identified time. The resident stated that he/she was in bed and put the call bell on to request staff to remove the soaker pad from under him/her. An identified personal support worker (PSW) came in and said “I'm not doing it” and left. There was low lighting in the room so the resident could not see if the PSW had removed the call bell. The resident could not find the call bell after the PSW left. The resident stated that he/she started calling out loud and an identified registered practical nurse (RPN) came in. The resident told the RPN that he/she thought the PSW had taken the call bell away. According to the resident, the nurse said that "it was mean for the PSW to have done that", and gave the call bell back to the resident. The resident stated that he/she was upset and hoped someone will talk to the PSW so the PSW would not do that to other residents. The resident had not reported the incident to other staff beside the identified RPN. The resident was interviewed on two occasions seven days apart by the inspector and had recalled same details of the incident.

Interview with the identified PSW indicated that he/she had changed the resident's incontinence brief earlier that evening and the call bell which was tied to the side rail may have fallen down. The PSW denied having said the phrase "I'm not doing it", and had not removed the resident's call bell with the intention that the resident could not call again. The PSW stated that he/she responded to the resident's call, went in the room to cancel the call, and came right out to get the RPN to go with him/her to explain to the resident why the resident could not have the pad from under him/her removed.

Interview with the identified RPN indicated he/she believed the PSW removed the call

bell so the resident would not call again. The RPN stated that he/she believed the PSW did not remove the call bell intentionally, as the PSW was going to leave the room to report to the RPN anyway, there was no need for the resident to keep calling. The RPN denied having said to the resident that the PSW was mean to have removed the call bell. The RPN indicated that better communication between the resident and the PSW would improve relationship, as the resident speaks slowly and softly and likes everything explained to him/her while the PSW works quickly. The RPN stated that the PSW could have taken the time to explain better to the resident that he/she needs to keep the soaker pad under him/her as the resident would be incontinent and would wet the bed. On the evening of the incident, the RPN did not consider the incident as suspected abuse/neglect, and therefore a report was not made to the management staff of the home and the Director at the Ministry of Health (MOH).

Interview with the administrator and the DOC confirmed that the suspected abuse/neglect incident occurred on the identified date was not reported to the management staff at the home, not investigated and not reported to the Director at the MOH. [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 and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: 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: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 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 has failed to ensure that staff assisting residents are aware of the residents' diets, special needs and preferences.

Observation made on January 5, 2015, at 12:30 p.m. in an identified dining room, noted resident #012 sitting at a feeding table with three other residents and were being assisted by two staff. The resident was being fed by an identified PSW at the time. There were several nosey cups of fluids noted on the table in front of the resident; all but one cup contained thickened fluid at nectar consistency. The one cup was noted to contain milk of regular consistency.

The identified PSW stated that the resident was on pureed diet with thickened fluids, and that all the cups in front of the resident were intended for the resident to take. The PSW indicated that all thickened fluids were supposed to be prepared by the dietary staff in the kitchen before meal service. The PSW was not aware that the cup of milk was not thickened to the required consistency to meet the special needs of the resident. [s. 73. (1) 5.]

2. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

Observation made on December 16, 2014, at 12:15 p.m. in an identified dining room, noted an identified PSW feeding two residents standing on two occasions. When asked by the inspector as to the reason for him/her standing to feed residents, the PSW stated that he/she was just feeding residents the last few spoons of food and therefore did not see the need to sit down to feed.

Interview with the dietary director confirmed that the PSW should have been sitting when assisting residents at meals. [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 staff assisting residents are aware of the residents' diets, special needs and preferences, and that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' rights to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation made on December 16, 2014, at 12:15 p.m. in an identified dining room during lunch meal service, noted residents' diet sheets displayed on a stand on top of the counter visible to all standing in front of the food service station.

Interview with the dietary director confirmed that the private health information contained in the diet sheets were made accessible to the public when displayed in the above mentioned location. The dietary director stated that he/she will put the diet sheets inside a binder from now on which will be kept at the food service station for staff to refer to at meal services. [s. 3. (1) 11. iv.]

2. The licensee has failed to ensure that the resident's right to meet privately with his or her spouse or another person in a room that assures privacy is fully respected and promoted.

Record review and interview with the spouse of resident #012 indicated that the home's staff have been asking the resident's spouse to leave the resident's room whenever the roommate was to receive personal care, or, be transferred in or out of bed by using a ceiling lift, even though there was a full privacy curtain in between the two beds.

Interview with identified PSWs and registered nursing staff indicated the rationale for staff's action was as followed: one PSW was taught at school to ask every one in the room to leave whenever care is provided; the spouse might not like the odor from the continence products when roommate was being changed; and there was not enough space to operate the ceiling lift when the spouse sat in the middle of the room etc.

Interview with an identified PSW confirmed that the privacy curtain did extend all the way around the two beds thus providing full privacy for the two residents in the room, and that there would be adequate space to operate the ceiling lift when resident #012's spouse sits at the bedside closer to the doorway as the roommate's bed was closer to the window.

Interview with the registered nursing staff and the DOC confirmed that the resident's

spouse can stay and continue the visit with the resident and should not have to leave the room whenever care is being provided to the roommate, unless the spouse chooses to do so him/herself. [s. 3. (1) 21.]

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).

Findings/Faits saillants :

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

Review of resident #007's care plan indicated a toileting schedule of two times per shift, whereas the kardex indicated toileting every two hours, toileting before and after meals, and toileting twice on days and evenings.

Interviews with an identified registered nursing staff and the RAI coordinator confirmed that the plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of the home's policy titled Emergency Starter Box Use, index 3-9, dated November 2011, stated that a medication from the emergency starter box (ESB) is used when a new medication order is received from the physician, which requires initiation of therapy prior to the next scheduled pharmacy delivery.

Record review of resident #005 noted an assessment conducted by the home's physician on an identified date and at an identified time, and an order for an antibiotic to treat respiratory symptoms for the resident. Review of the physician's order revealed that the order was transcribed four and a half hours later, and the medication was administered eight hours later by a registered nursing staff on the following shift.

Interview with the identified registered nurse who transcribed the physician's order indicated that he/she was following the home's established time for daily medication administration which was at 8 p.m. The RN stated that the resident's health condition did not appear bad enough to start the medication immediately. Interviews with an identified RPN and the DOC confirmed that the antibiotics prescribed should have been administered soon after it was prescribed, and that the RN should have used the supply which was available in the ESB. The RN did not comply with the home's policy on emergency starter box use. [s. 8. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports.

Review of the home's nursing policy titled Resident Abuse, index NUM-IV-02, dated May 30, 2013, and the administration policy titled Zero Tolerance Policy, index ADM-II-46, updated on March 2, 2013, indicated that the policies do not contain an explanation of the duty under section 24 of the Act to make mandatory reports.

Interviews with the administrator and the DOC confirmed that the legislative requirements were not included in the home's current policies to promote zero tolerance of abuse and neglect of residents. [s. 20. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that an abuse of a resident by anyone or neglect of the resident by staff has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director.

Interview with resident #003 indicated an incident which occurred on an identified date at an identified time. The resident stated that he/she was in bed and put the call bell on to request staff to remove the soaker pad from under him/her. An identified personal support worker (PSW) came in and said "I'm not doing it" and left. There was low lighting in the room so the resident could not see if the PSW had removed the call bell. The resident could not find the call bell after the PSW left. The resident stated that he/she started calling out loud and an identified registered practical nurse (RPN) came in. The resident told the RPN that he/she thought the PSW had taken the call bell away. According to the resident, the nurse said that "it was mean for the PSW to have done that", and gave the call bell back to the resident. The resident stated that he/she was upset and hoped someone will talk to the PSW so the PSW would not do that to other residents. The resident had not reported the incident to other staff beside the identified

RPN. The resident was interviewed on two occasions seven days apart by the inspector and had recalled same details of the incident.

Interview with the identified PSW indicated that he/she had changed the resident's incontinence brief earlier that evening and the call bell which was tied to the side rail may have fallen down. The PSW denied having said the phrase "I'm not doing it", and had not removed the resident's call bell with the intention that the resident could not call again. The PSW stated that he/she responded to the resident's call, went in the room to cancel the call, and came right out to get the RPN to go with him/her to explain to the resident why the resident could not have the pad from under him/her removed.

Interview with the identified RPN indicated he/she believed the PSW removed the call bell so the resident would not call again. The RPN stated that he/she believed the PSW did not remove the call bell intentionally, as the PSW was going to leave the room to report to the RPN anyway, there was no need for the resident to keep calling. The RPN denied having said to the resident that the PSW was mean to have removed the call bell. The RPN indicated that better communication between the resident and the PSW would improve relationship, as the resident speaks slowly and softly and likes everything explained to him/her while the PSW works quickly. The RPN stated that the PSW could have taken the time to explain better to the resident that he/she needs to keep the soaker pad under him/her as the resident would be incontinent and would wet the bed. On the evening of the incident,
the RPN did not consider the incident as suspected abuse/neglect, and therefore a report was not made to the management staff of the home and the Director at the Ministry of Health (MOH).

Interview with the administrator and the DOC confirmed that the suspected abuse/neglect incident occurred on the identified date was not reported to the management staff at the home, not investigated and not reported to the Director at the MOH. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the substitute decision maker (SDM) if payment is required.

Record review of residents #001, and #002 indicated the residents had dental screening during an identified week in 2013 and documented "R" as refused. There was no record indicating an offer or dental screening conducted for 2014.

Record review of resident #004 indicated that the resident had dental screening for 2013. Record was not available to indicate that a dental screening was offered or conducted for 2014.

Interview with the DOC confirmed that dental screen for the residents was not offered or conducted in the home for 2014. [s. 34. (1) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (6) The following persons may not be members of the Family Council:
1. The licensee, and anyone involved in the management of the long-term care home on behalf of the licensee. 2007, c. 8, s. 59 (6).
2. An officer or director of the licensee or of a corporation that manages the long-term care home on behalf of the licensee or, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129, as the case may be. 2007, c. 8, s. 59 (6).
3. A person with a controlling interest in the licensee. 2007, c. 8, s. 59 (6).
4. The Administrator. 2007, c. 8, s. 59 (6).
5. Any other staff member. 2007, c. 8, s. 59 (6).
6. A person who is employed by the Ministry or has a contractual relationship with the Minister or with the Crown regarding matters for which the Minister is responsible and who is involved as part of their responsibilities with long-term care home matters. 2007, c. 8, s. 59 (6).
7. Any other person provided for in the regulations. 2007, c. 8, s. 59 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that a staff member of the home is not a member of the Family Council.

Review of the Family Council meeting minutes indicated one of the home's staff has been signing off in the minutes as the president and chair of the Family Council.

Interview with the identified staff indicated his/her role on the Family Council is that of a chair person. Interview with the administrator confirmed that the staff was acting as the chair of the Family Council other than as a council assistant as required by legislation. [s. 59. (6) 5.]

WN #10: 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 has failed to ensure that planned menu items including alternate choices are offered at each meal.

Observation made on December 16, 2014, at 12:15 p.m. in an identified dining room noted that PSWs served out dishes of minced food to residents around the tables. No alternate choices were shown to the residents prior to them receiving minced food.

Observation made on December 29, 2014, at 12:15 p.m. in another identified dining room, noted some residents being served minced texture diets. No alternate choices were offered to residents before plates of food were served.

Interview with an identified PSW revealed that dietary staff went ahead to serve minced food to residents and no alternate choices were shown to residents. Interview with the dietary director confirmed that alternate choices should have been shown to the residents before the minced texture food were served to them. [s. 71. (4)]

WN #11: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the
residents and families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Interview with the social worker indicated he/she was not sure if a satisfaction survey was conducted for 2014. Social worker stated that he/she would look for any returned survey forms and forward to the inspector. Requests for copies of the completed 2014 surveys or analysis of the results were made on four occasions to the social worker and the administrative office staff, none were presented to the inspector.

Interview with the DOC confirmed that a satisfaction survey was not conducted for 2014. The DOC stated that usually the social worker sends the survey forms to all families. [[s. 85. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for the maintenance program has a post-secondary degree or diploma, and a minimum of two years experience in a managerial or supervisory capacity.

Record review and interview with the maintenance manager noted the lead for the maintenance program did not have a post-secondary degree or diploma, and did not have a minimum of two years experience in a managerial or supervisory capacity.

Interview with the administrator confirmed that the maintenance manager did not possess credentials required by legislation. [s. 92. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

Record review indicated that resident #011 has a stage two pressure ulcer on his/her coccyx. The resident has left-sided weakness, is cognitively impaired and tends to scratch his/her coccyx ulcer with his/her right hand causing the ulcer to be worsened. A protective posey mitten was ordered by the physician on an identified date, consented to by the substitute decision maker, and applied to the resident's right hand to prevent him/her from scratching the ulcer.

The home's staff were noted using a form titled Norwood Long Term Care – Using Mitten (Restraint) form to document visual check by PSWs every two hours as stated in the care plan. There was no evidence to indicate that the resident was monitored at least hourly by the home's staff.

Interview with an identified RN and the DOC confirmed that the resident had been monitored every two hours instead of the hourly frequency as required by legislation. [s. 110. (2) 3.]

2. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff at least every eight hours, and at any other time based on the resident's condition or circumstances.

Record review indicated that resident #011 has a stage two pressure ulcer on his/her coccyx. The resident has left-sided weakness, cognitive impairment, and tends to scratch at his/her coccyx ulcer causing the ulcer to worsen. The home's staff obtained a physician's order on an identified date and consent from the substitute decision maker to apply a protective posey mitten on the resident's right hand.

Record review indicated that nursing staff are supposed to be documenting on the electronic medication administration record (eMar) after they have checked the mitten on the right hand of the resident, to ensure that it is applied properly and is not too tight every eight hours. However, record review indicated that the checking did not take place during the month of December 2014, until December 30, 2014, after the inspector brought the issue to the attention of the DOC.

Interview with an identified registered nurse, RAI coordinator and the DOC confirmed that there was no evidence to support that the evaluation of the resident's condition and the effectiveness of the restraint were conducted every eight hours. [s. 110. (2) 6.]

WN #14: 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).

Findings/Faits saillants :

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

Observations conducted on December 18 and December 22, 2014, revealed that in an identified four-bed shared bathroom an unlabeled white urine collection receptacle was stored on the grab bar located above the toilet, and that a raised toilet seat was stored on the floor on its side in an upright position.

Interview with an identified registered nurse confirmed that the urine collection receptacle should be labeled, and that the raised toilet seat being stored on the bathroom floor was an infection control issue. [s. 229. (4)]

2. Observation made on January 02, 2015, at 11:02 a.m. on an identified unit revealed an identified PSW not wearing gloves when assisting an identified RN in a dressing change for a resident's coccyx ulcer. The PSW removed resident's continence product and touched resident's buttocks during dressing change without wearing protective gloves. After dressing change was completed, the PSW applied continence product onto the resident, pulled resident's pants up, and pulled back privacy curtains without performing hand hygiene.

Interview with the PSW confirmed that he/she did not wear gloves when assisting to hold residents buttocks open during dressing change. Interview with the RN after the dressing change indicated that he/she could not remember if the PSW had worn gloves.

Interview with the DOC confirmed that the PSW assisting with the dressing change should have worn gloves as the PSW was touching areas around the wound and can be

exposed to body fluids. [s. 229. (4)]

3. Observation made on December 17, 2014, at 10:45 a.m. and at 3:40 p.m. noted an identified laundry aide delivering clean laundry in an open two-shelf laundry cart. Clothing items were piled high on the top shelf of the cart, and clothing items were not covered during the delivery. On one occasion, the laundry aide was observed trying to push the cart into the elevator and clothing items almost fell off the cart.

Interview with the laundry aide stated that the home has provided a cover for the laundry cart however it was not being used. The laundry aide stated that he/she will start using the cover for the cart from now on.

Observation made on December 18, 2014, at 11:20 a.m. noted an unlabeled tooth brush in the washroom of resident room #25. The washroom was shared by two residents.

Interview with an identified PSW stated that he/she was not sure to whom the toothbrush belonged. The PSW agreed that the tooth brush should be labeled, and was going to find out to whom it belonged and put a label on it. [s. 229. (4)]

Issued on this 4th day of February, 2015

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

Original report signed by the inspector.