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 9, 2014	2014_157210_0011	T-000081-14	Resident Quality Inspection

Licensee/Titulaire de permis

848357 ONTARIO INC.
33 Christie Street, TORONTO, ON, M6G-3B1

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

THE O'NEILL CENTRE
33 CHRISTIE STREET, TORONTO, ON, M6G-3B1

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

SLAVICA VUCKO (210), MATTHEW CHIU (565), VALERIE PIMENTEL (557)

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 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 2014.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), social services worker, environmental services staff, environmental services manager, cook, food service workers (FSW), nurse managers (NM), physiotherapist (PT), programs manager, programs staff, director of nursing (DON), administrator, infection prevention and control (IPAC) leader, registered dietitian (RD), clinical informatics manager, substitute decision makers (SDM).

During the course of the inspection, the inspector(s) conducted tour of all home areas, observed meal and snack service, reviewed clinical records, observed provision of care, reviewed Residents' and Family Council minutes, the home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. 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 is maintained in a safe condition and in a good state of repair.

Observation performed on June 13, 2014, revealed that the wall in the tub room on one of the floors and shower room on another floor were damaged. The sharp tile edges, the drywall and the rusty metal were exposed.

Interview with identified staff and the environmental services manager, confirmed that the identified damages had the potential risk for injuries to staff and residents. Observation performed on June 24, 2014, revealed that the damaged wall tiles in the shower room were covered with aluminum corner guards but the fifth floor tub room damages were not fixed. On June 26, 2014, it was observed that the damaged wall tiles in the tub room were covered with vinyl wall guards and corner guards.

Interview with the environmental services manager confirmed that the home requested quotations from several external contractors for repairing the damages and the covering was only a temporary measure. [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 is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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, 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.

Record review and interview with registered staff indicated when altered skin integrity is observed, staff is expected to complete a skin and wound assessment tool that is located in the assessment tab in the electronic documentation.

On June 13, 2014, observation of one of the resident #294's arms revealed bruising on the elbow, multiple small bruises, and a dressing to one of the feet.

Interviews with the registered staff confirmed that the skin and wound assessment tool was not completed for the above identified skin issues/problems. [s. 50. (2) (b) (i)]

2. On June 13, 2014, observation of resident #222 revealed a bruising on the top of one of his/her hands.

Record review and interviews with the registered nursing staff confirmed that the skin and wound assessment tool for resident #222 was not completed for the above mentioned bruise. [s. 50. (2) (b) (i)]

3. On June 13, 2014, observation of resident #201 revealed bruising on one of his/her hands and on June 23 the bruising was still evident.

Record review and interviews with the registered nursing staff confirmed that the skin and wound assessment tool for resident #201, was not completed for the above mentioned bruise. [s. 50. (2) (b) (i)]

4. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, is reassessed at least weekly by a member of the registered nursing staff.

On June 13, 2014, observation of resident #222's right lower leg revealed a dressing, discoloration and redness.

Record review, revealed that the skin and wound assessment was not completed consistently on a weekly basis for his/her leg on seven occasions out of 24 weeks in 2014.

Interviews with the registered nursing staff confirmed that the skin and wound assessment tool was not completed on a weekly basis for this identified skin problem. [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, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

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

Review of the written plan of care of resident #278, in relation to toileting and continence care indicates the resident requires limited assistance for the physical process of toileting with a goal the resident to ask and receive the necessary assistance. The interventions identified were: the resident not to be left unattended while on the toilet, the resident prefers washroom and toilets independently, may need some light assistance with managing the incontinent product or pericare at times, to be reported to registered staff if there is any decrease in ability to toilet self hygienically, safely and appropriately. In the section for potential to restore function, urinary incontinence, characterized by inability to control urination related to impaired mobility and cognitive deficit states that a urinal should be placed within the resident's reach and assistance to be provided, the continence status to be re-assessed quarterly, and the pericare to be rendered after each episode of incontinence. Review of the MDS documentation indicated resident was on a toileting schedule. Interview with a PSW and RN indicated if someone is on a toileting schedule the same has to be documented on a flow sheet and it has to be part of the written plan of care,

which was not the case with this resident. Interview with an identified staff indicated that the resident is not assisted according to a certain toileting schedule, but he/she has a toileting routine usually before breakfast, before lunch and after lunch. Further the identified staff stated that this resident was not able to call for help, he/she needs extensive assistance with toileting and the urinal is located at the resident's bed only for night time or if the resident is in bed.

On June 23, 2014, at 11:35 a.m. the resident was observed in his/her room standing beside the bed with the incontinent product down waiting for someone to help him/her. The identified staff was on break and nobody was aware that the resident needed assistance.

The written plan of care for resident #278 does not give clear direction to direct care staff in relation to the level of assistance with the continence care and the toileting routine of the resident. [s. 6. (1) (c)]

2. Review of the written plan of care for resident #221 in relation to personal hygiene indicated a goal for oral care the resident to maintain good oral hygiene with assistance and resident to be physically assisted by one person.

Interview with a PSW in relation to mouth care for resident #221 indicated staff do not always perform the mouth care with a tooth brush and paste but they use a swab and mouth wash. The identified staff stated the resident sometimes refuses the toothbrush because he/she is not comfortable with the tooth brush. Another identified staff indicated he/she uses a tooth brush and paste for resident #221's mouth care.

The written plan of care did not set out clear direction to direct care staff in relation to oral hygiene. [s. 6. (1) (c)]

3. Review of the clinical record of resident #11 indicated the resident is insulin dependent. According to the physician's order in 2013, the resident's blood sugar was to be checked four times a day. The resident was on one type of insulin with breakfast, another type of insulin after breakfast, after lunch and dinner. A third type of Insulin to be injected subcutaneously as needed and per sliding scale: if BS is greater than 20 to give five units insulin and call MD.

Another order in 2014, indicated the third type of insulin 5 units to be given stat for BS 30.0.

Interview with an identified registered staff indicated he/she interpreted the orders this way: if the BS is 30.0 and more he/she would give 5 units insulin as per the order from 2013, (for BS more than 20.0) and 5 units more as per the order from 2014, (for BS more than 30.0) , then he/she would call the MD. He/she was not able to explain why the MD was not called by the registered nursing staff for BS more than 20.0 but less than 30.0 in the period from May to June 2014 but only one time in June 2014 when the BS was out of the measuring range of the instrument. He/she was not able to explain clearly the meaning of the word "stat" in the order from 2014 if the order was for one time only (immediately) and not to repeat. He/she interpreted it as a continuous order but the NM confirmed the word "stat" was not giving clear direction to all registered nursing staff. [s. 6. (1) (c)]

4. 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 of resident #267 indicated the resident received new dentures at the beginning of 2014. One month later he/she complained the dentures were loose, he/she was seen by a dentist and he/she was recommended to wear them in order to adjust. Interview with the resident confirmed the resident was still not comfortable with the dentures because they were loose. The resident stated he/she complained several times to staff. Interview with registered nursing staff indicated staff was not aware that the resident had problems with the dentures. Interview with another identified staff indicated he/she was aware that resident did not wear the dentures during lunch time and ate without them. He/she confirmed of not notifying the registered staff about the resident's loose dentures. Review of two quarterly assessment, Resident Assessment Instrument (RAI), in 2014, did not identify that the resident had dentures and/or removable bridge. Interview with registered staff indicated he/she was not aware of the denture problems of the resident in order to update the care plan in 2014 when the resident received the dentures. [s. 6. (4) (a)]

5. Interview with an identified staff indicated resident #321 demonstrated responsive behaviors identified as being resistive to care, physically abusive and angry on a daily basis, since the admission. The resident's written plan of care identified the responsive behavior as yelling, screaming, kicking, hitting, lashing out, punching, scratching and twisting staff fingers. The goals and interventions to manage these behaviors were to allow the resident time to respond, not to invade his/her space, to

gain his/her attention before touching and to take him/her to a quiet area if behaviors are present. Interview with the registered nursing staff indicated the PSWs must report observed responsive behaviors to the registered nursing staff in order to be documented in behavioral progress notes. The registered nursing staff would assess if the present interventions were effective and if not would communicate to the NM and behavioral management lead to initiate a daily observation sheet (DOS) if the responsive behavior was still present

Record review revealed that the responsive behavior was documented by the registered nursing staff in the progress notes only one time in March, April and June 2014.

Interviews with identified staff confirmed they do not report on a daily basis the behaviors of resident #321 to the registered nursing staff, in order to evaluate the effectiveness of the present interventions for the written plan of care be revised.

The interdisciplinary team members did not collaborate with each other in assessment of the resident's responsive behaviours. [s. 6. (4) (a)]

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

Review of the written plan of care and interview with SDM in relation to sleep patterns and personal preferences indicated resident #221's usual bedtime is 9:00 p.m.

Interview with an identified staff indicated resident stays in the hallway after the dinner and he/she assists the resident in bed at 8:00 p.m. latest. The identified staff stated he/she was not aware of the written plan of care interventions. [s. 6. (7)]

7. Review of the written plan of care for resident #221 in relation to programs indicated the resident to be offered activities in which resident has shown interest. The resident likes exercises and special events that involve entertainment, to be offered sensory awareness, to be invited and assisted as needed to activities of interest, to be provided clear and loud instruction before and during program, to be provided with 1:1 "beauty Club/Light Touch" where resident enjoys getting his/her hands massaged and his/her back rubbed, to be provided with 1:1 pet therapy, Tai Chi and active games, resident enjoys 1:1 exercise/active games such as stretching and ball toss, resident enjoys music programs.

Review of clinical record and interview with the program therapist, recreation staff and program manager indicated resident #221 has been offered to go to church only but not to the other activities as per the written plan of care. [s. 6. (7)]

8. Review of the written plan of care for resident #208 indicated the resident to be encouraged to attend musical group activities, to be provided 1-2 programs 3-4 times a week, to be redirected for activity tasks as needed and as possibly by gently touching resident, to be called by name to capture attention, physically demonstrating activity actions, to be provided 1:1 programs like 1:1 visits 4-5 times a week, 1:1 aroma therapy 2-3 times a week, relaxation music 2-3 times a week, resident ethnic music 2-3 times a week, out and about and some large groups special events, to provided 1:1 bedside activities 3-4 times weekly and be involved in some large group events, programs staff will provide cultural music, pastoral contact, 1:1 visits, therapeutic touch, wandering out and about and aromatherapy and light massage.

Interview with a program staff indicated resident #208 receives music therapy only when the family visits and not by the programs staff. The resident is not involved in the programs as described in the written plan of care. [s. 6. (7)]

9. Review of resident #201's record revealed that upon return from the hospital in 2013, the physician ordered a monthly fasting blood sugar (FBS) to be completed once a month for four months. Review of the clinical record confirmed there no any FBS results for the period of four months.

Interview with registered nursing staff confirmed that the FBS was not performed for resident #201 for the period of four months as per the physician's order. [s. 6. (7)]

10. On June 13, 2014, observation of resident #294, revealed a dressing to one of the feet. Interview with registered staff indicated that the dressing was applied because the toenails were cut too short by an identified registered staff.

Review of the written plan of care indicated the resident to receive foot care by the foot care nurse, because of certain diagnoses.

Interview with the registered nursing staff confirmed that the resident's nails were not clipped by the foot care nurse as specified in the resident's plan of care. [s. 6. (7)]

11. Review of the written plan of care for resident #211 indicated the resident requires total care with oral care due to limited mobility of upper extremity. Interview with the resident indicated the he/she does not get help with oral hygiene.

Interview with an identified staff indicated staff assists the resident in the morning and evening with the oral care. The staff will set up the tooth brush with paste and the resident would do the oral care by him/herself as per the general restorative directives that the abilities of every resident should be encouraged. The staff was not aware of the resident's plan of care. [s. 6. (7)]

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

Review of the clinical record of resident #11 indicated the resident is insulin dependent. The resident's blood sugar (BS) is to be checked four times a day, according to the physician's order from 2013. The resident is on one type of insulin with breakfast, another type of insulin after breakfast, after lunch and dinner. Third type of Insulin to be injected subcutaneously as needed and per sliding scale: if BS greater than 20 to give 5 units insulin and call MD. Another order from 2014, indicated the third type of insulin, dose 5 units to be given stat for BS 30.0

Interview with a registered staff confirmed that he/she would call the MD only if the BS is more than 30.0. Review of the clinical record for resident #11 indicated for a period of 37 days in 2014, the BS results were higher than 20.0 during 35 days, during at least one of the measurements performed four times per day. The clinical record and interview with RN confirmed that for the above mentioned period registered staff called the MD only one time in 2014, for high blood sugar (out of range). All three blood sugar results from the same day were higher than 29. The physician was not called each time when the resident's blood sugar was greater than 20.0 as per the physician's order. [s. 6. (7)]

WN #4: 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 failed to ensure the policy put in place is in compliance with and in accordance with all applicable requirements under the Act.

The home's policy Routine Practices, Index # I.D.: IFC-B15, revised July 10, 2013, the section for use of gloves (c) states "wear gloves for handling items visibly soiled with blood, body fluids, secretions or excretions when the health care worker has open skin lesions on the hands". The policy is not according to the best practice guidelines Provincial Infection Disease Advisory Committee (PIDAC).

Interviews with the registered nursing staff and the staff educator confirmed that staff must wear gloves always when dealing with bodily fluids according to the best practices described in PIDAC.

A Review of the policy Cleaning of Medical/Personal Care Equipment and Contact Surfaces, Index I.D.: E-80, revised April 30, 2014, does not include the process of cleaning the nail clippers. The policy does not provide clear direction to staff on how to clean or sanitize personal care equipment such as nail clippers. [s. 8. (1)]

2. The licensee failed to ensure that the home's policy Tuberculosis Surveillance for Employees, Index # I.D.: B-05-10, revised May 22, 2013, is complied with. The section for IPC program states "All employees are required to have a 2-step Manotoux test done within six (6) months before starting work or within fourteen (14) days of employment to establish an accurate baseline for ongoing tuberculosis surveillance".

Review of the employment record of an identified staff, and interviews with a NM and the administrator revealed the identified staff was hired in 2014 and on the day of the inspection there was no record of a TB skin test in the employees' personnel file or in the staff TB surveillance binder. The form was submitted to the inspector the following day with a date May 2014. The home's policy was not complied with. [s. 8. (1)]

WN #5: 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, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system are prepared, using methods to preserve taste, nutritive value, appearance and food quality.

Interview with resident #267 indicated the food did not taste good.

On June 25, 2013, at 9:30 a.m. the inspector observed the FSW pouring freely a thickener from a can into the blender containing apricots. An interview with the FSW revealed that the FSW did not measure the amount of the thickener because he/she knew what the consistency should look like. The FSW knew how many pureed desserts should be prepared for the lunch, but he/she did not use the production sheets to identify the quantity required to make the desert.

Interview with a second FSW who was preparing puree lemon meringue pie for supper revealed he/she thickened the lemon meringue pie with thickener. Review of the recipe indicated milk to be used to thin the puree out. The FSW confirmed that he/she did not use the production sheets and he/she did not follow the recipe.

The inspector and Food Service Manager (FSM) reviewed the production binder containing the production sheets for the period from June 16 to 30, 2014, and production sheets for the FSW were not in the binder.

Staff interviews confirmed that the food was prepared without following the standardized recipes and production sheets in order to preserve taste, nutritive value, appearance and food quality. [s. 72. (3) (a)]

2. The inspector observed on June 25, 2014, during the food production and preparation for lunch that the cook was preparing tomato soup. The menu posted identified tomato vegetable soup for lunch. When the menu was reviewed with the cook(s) it indicated tomato vegetable soup, the recipe also indicated tomato veg frozen soup. The cook made the tomato soup from a can and he described that

he/she made a roux of butter and flour to add to the soup to make it taste better. The cook confirmed there is no recipe for the roux and that he/she did not add vegetables to the soup. After this observation the cook spoke with the FSM and they obtained the correct recipe and made adjustments to the soup.

Staff interviews with identified staff and RD confirmed that by adding a roux the tomato soup was not prepared according to the recipe and that the nutrient value of the soup was altered. [s. 72. (3) (a)]

WN #6: 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 failed to 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.

Record review of the home's educational records identified an average of 83 per cent of the staff received retraining in IPAC in 2013.

The home did not ensure there was 100 per cent compliance of retraining to the direct care staff in infection prevention and control. [s. 76. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Interview with the SDM of resident #221 indicated that some that some of the resident's clothes were damaged in the laundry in 2013, and the SDM complained to the home at that time. Interview with the PSW, registered staff and social services worker confirmed that a client service response form should have been used to document the complaint.

Record review and interview with the registered staff and the social services worker confirmed that there was no documented record for this complaint. [s. 101. (2)]

WN #8: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the designated staff member who co-ordinates the IPAC program has the education and experience in infection prevention and control practices, including, infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

Interview with the DON indicated that the previous designated leader of the IPAC program was employed until May 2014 and was enrolled in IPAC program to be completed on June 2014. During the inspection no proof of enrollment was provided until 10 days later. The certificate indicated basic training in IPAC for long term care homes. The present IPAC leader, one of the NMs, who started in this role at the beginning of June 2014, was, at the time of inspection, unable to provide proof of IPAC education or enrollment in education specific to infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

On June 18, 2014, during the inspection the home was declared in a respiratory outbreak by Toronto Public Health. Interview with another identified staff, indicated he/she was appointed to manage the outbreak and he/she did not have the education in IPAC including, infectious diseases, cleaning and disinfection, data collection and

trend analysis, reporting protocols, and outbreak management. [s. 229. (3)]

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

During observation performed on June 13, 2014 at 11:00 a.m. in one of the shared washrooms a non-labeled urine collection basin was observed on the toilet tank.

During observation performed on at an identified date and time on one of the floors, during respiratory outbreak, an identified staff was noted in the hallway wearing a mask as part of the personal protective equipment (PPE) for droplet precautions on his/her neck, and going from one to another resident's room. Interview with registered staff confirmed that the mask should be applied and removed in the identified room on droplet precautions and after resident care the mask should be thrown away in the isolated resident room. [s. 229. (4)]

3. The inspector observed on June 13, 2014, resident #294, with a dressing to his/her foot. Interview with registered nursing staff indicated the resident's toe nails were clipped with a nail clipper that is communal.

Interviews with identified staff confirmed that the home uses communal nail clippers. Interview with several staff described different methods of cleaning the communal nail clippers such as using alcohol swabs, virox sheets, or hand sanitizers. One registered nursing staff indicated that they used a kidney basin to pour virox solution into and then let the nail clippers soak.

The identified staff, NM, and DON confirmed that there is no standardized process for cleaning and sanitizing the nail clippers in between resident use. The staff have not implemented the IPAC best practices according to PIDAC in relation to cleaning of personal care equipment. [s. 229. (4)]

4. The licensee failed to ensure that a hand hygiene program is in place in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

The inspector observed on June 12, 2014, that resident rooms do not have hand hygiene agents at the point of care, beside the resident's bed.

Interviews with identified staff indicated that when they provide morning care they take the hand sanitizer into the resident rooms and when the personal care is completed they lock it up in the nursing storage area. Staff confirmed that when the personal care is provided throughout the day they do not take the hand sanitizers with them.

Interviews with the IPAC lead confirmed that the home does not have point of care hand hygiene agents. [s. 229. (9)]

Issued on this 15th day of August, 2014

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

SLAVICA VUCKO