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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2014	2014_263524_0030	L-000700-14	Resident Quality Inspection

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0

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

PEOPLECARE TAVISTOCK
28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0

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

INA REYNOLDS (524), JULIE LAMPMAN (522), RHONDA KUKOLY (213)

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): September 2, 3, 4, 5, 8, 9, 2014.

Concurrent inspections include: 000199-14 and 000563-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Administrator, the Director of Nursing Care, the Assistant Director of Care, the Director of Nursing Services, the Director Policy and Legislation, the Director of Quality Outcomes, the Director of Environmental Services, 1 Registered Nurse, 3 Registered Practical Nurses, 9 Personal Support Workers, 1 Maintenance staff, 2 Housekeeping Aides, 44 Residents and 3 Family Members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed care and activities provided to residents, meal service, medication administration, medication storage areas, resident/staff interactions, infection prevention and control practices and, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, staff education records, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care related to

falls prevention is provided to the resident as specified in the plan.

Record review of the plan of care for resident #27 revealed falls protection device was to be used for the resident while resident is in bed for safety.

On September 4, 2014 resident #27 was observed sleeping in bed. There was no falls protection device observed at the resident's bedside. This was confirmed by the Personal Support Worker.

Interview with the Assistant Director of Nursing confirmed the expectation that the resident should have a falls protection device in place while in bed as per the resident's plan of care. [s. 6. (7)]

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

a) Record review of the plan of care for resident #1 revealed a falls protection device is required when the resident is in bed.

Review of the kardex task record on Point of Care for Resident #1 on September 9, 2014 revealed: "Falls prevention - tasks require documentation: document every shift". There were a number of places on the kardex record with missing documentation; the provision of a falls protection device was not recorded on eleven out of thirteen days (85%) between August 27, 2014 and September 8, 2014.

b) Record review of the plan of care for resident #27 revealed the resident uses multiple individual falls prevention strategies.

Review of the documentation in Point of Care (POC) for resident #27 revealed personal support workers were documenting "interventions as per kardex" and do not specifically document resident specific falls prevention strategies as set up in POC. This was confirmed by the Personal Support Worker (PSW).

Review of the home’s "Documentation by PSW" policy #009080.00 dated 2011/05/21 revealed: “Individual resident tasks will be documented as assigned” by the PSW on POC.

Interview with the Assistant Director of Nursing and the Director of Nursing Services

confirmed the expectation that staff document individual falls prevention strategies used for the resident in Point of Care. [s. 6. (9) 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 the care set out in the plan of care related to falls prevention is provided to the resident as specified in the plan and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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.

a) Review of the home's "Screening and Immunization Program" Policy #003010.00 revealed: "The RN/RPN will screen residents for FRI, MRSA and VRE as per resident medical directives."

Review of clinical records for resident #29 and resident #30 revealed that the residents did not receive MRSA and VRE Admission Screening.

The Assistant Director of Nursing confirmed that resident #29 and #30 did not receive MRSA and VRE Admission Screening. The Assistant Director of Nursing revealed the

home's expectation is that all residents are screened for MRSA and VRE upon admission and that the home's Screening and Immunization Program Policy is complied with.

b) Review of the home's "Pet Visitation" policy #003120-00 revealed: "The animal owner has the responsibility to ensure that they will provide annual immunization report (rabies)."

A review of three Pet Handler agreements for dogs visiting the home revealed there were no immunization records on file for the dogs.

The Assistant Director of Nursing confirmed there was no documented evidence of immunization records on file for the dogs. The Assistant Director of Nursing revealed the home's expectation is that the Pet Visitation policy is complied with.

c) Observations in the medication storage room on September 8, 2014 revealed the controlled substances for destruction bin was found unlocked. A blister package card containing 1 tablet of Ativan 0.5mg and a blister package card containing 10 tablets of Tylenol #2 was unlocked and accessible in the locked medication storage room.

The home's "Drug Destruction and Disposal" policy #5-4 (a Medical Pharmacies policy dated 01/14) was reviewed and indicates:
"All medications which are surplus, excluding Monitored Medications (narcotic or controlled drugs), are destroyed by the team of nursing staff and one other staff member appointed by the Director of Nursing. Monitored Medications are destroyed by the team of physician or pharmacist and a nursing staff delegate. 14. Retain the medications in a double-locked area within the home, separate from those medications available for administration to a resident."

Interview with the Assistant Director of Care and the Director of Nursing Care confirmed the expectation that the controlled substances for destruction bin is kept locked within the locked medication storage room at all times and that the only person holding the key for this bin is the pharmacist. [s. 8. (1)]

Additional Required Actions:

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

Observation of resident home areas during a tour on September 2, 2014 revealed:
-Numerous hallway walls, door and door frames were damaged, scraped and paint was chipped;
-Corner of wall by first floor elevator was gouged, chipped and damaged;
-First floor dining room had chipped floor tiles and missing tiles under the refrigerator; and, floor at entrance to servery was gouged.

Observation of identified resident bathrooms on September 3 and 4, 2014 revealed:
-Multiple walls were observed to be damaged, scraped and paint chipped; toilet caulking was stained; floors were heavily stained; and, holes in walls were not filled or repaired.
-Bolt cap covers were missing on toilet;
-Multiple bathroom doors and bedroom closets had numerous scrapes in the wood.

Observation of multiple resident rooms on September 3 and 4, 2014 revealed numerous wood floor mouldings were damaged, scraped and in need of paint.

Interview with the Administrator, Director of Environmental Services and maintenance staff confirmed the need for repairs. The Administrator confirmed the expectation that the home is maintained in a good state of repair. [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 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

On September 3, 2014 resident #27 was observed in a wheelchair in a tilted position.

Review of the clinical record for resident #27 revealed the absence of a documented PASD assessment. Further record review revealed the absence of documentation in the resident's plan of care related to the use of a PASD.

Interview with the Personal Support Worker and Registered Practical Nurse confirmed the resident does use a tilt wheelchair to prevent the resident from sliding from the chair and falling out. The Personal Support Worker confirmed the lack of documentation in the resident's plan of care related to the use of a tilt wheelchair.

Interview with the Director of Nursing Services and Assistant Director of Nursing confirmed the absence of documentation related to tilting of the resident's wheelchair. The Director of Nursing Services and Assistant Director of Nursing confirmed this would be considered a PASD. The Assistant Director of Care confirmed the expectation that an assessment of the resident is completed prior to the use of a PASD and that the plan of care be updated to include the use of the PASD. [s. 33. (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 a PASD is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident height upon admission and annually thereafter.

A clinical record review of 13 residents revealed that 12 residents (92%) did not have a height measurement taken annually.

Staff interview with the Director of Quality Outcomes on September 3, 2014 confirmed residents' heights are not taken annually and that the home's expectation is that all residents are to be measured for height on admission and annually.

Interview with the Director of Nursing Services on September 4, 2014 revealed that there was no policy or procedure developed to guide staff regarding measuring and recording with respect to each resident height annually. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident height upon admission and annually thereafter, to be implemented voluntarily.

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. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to behaviour management at intervals provided for in the regulations: O. Reg 79/10 s. 221 (2) 1: the staff must receive annual training in all areas required under subsection 76 (7) of the Act.

Record review of the home's Educational Attendance Record Form revealed multiple staff members had not received training for the education session on behaviour management in 2013. One staff member's last documented training session on behaviour management was in 2009.

Interview with the Administrator on September 8, 2014 confirmed there was no documented evidence of behaviour management training in the education records for multiple staff members for 2013. The home was unable to provide the number of staff members that had not received training on behaviour management in 2013. [s. 76. (7) 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 all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to behaviour management at intervals provided for in the regulations: O. Reg 79/10 s. 221 (2) 1: the staff must receive annual training in all areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #7: 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 or a medication cart that is secure and locked.

Observations of the medication administration pass revealed the medication cart was found unlocked and unattended and the Registered Practical Nurse administering medications left the medication cart unlocked again when he/she walked down the hall and into a room to administer a resident's medication. The Registered Practical Nurse confirmed the expectation that the medication cart is locked at all times when unattended.

The home's "Medications - Security and Accountability" policy #011020.00 states: "All medications will be stored in a safe, secure manner with access limited to registered staff only. Secure all medications locked in accordance with legislative requirements". [s. 129. (1) (a)]

2. An unlocked and unattended treatment cart was observed in the home area lounge. The cart contained numerous prescription creams, isopropyl alcohol and Dovidine.

The Registered Practical Nurse confirmed the treatment cart was unlocked and that the cart should be locked at all times. Interview with the Assistant Director of Nursing confirmed the expectation that the treatment cart be locked at all times when unattended. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

An incident occurred as reported by the home involving resident #14 who presented with responsive behaviours, resident #15 and a staff member. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved.

Record review revealed the residents' substitute decision-maker were initially notified of the incident however, the home failed to report the results of the investigation to the residents' substitute decision-maker upon completion of the investigation. Review of the home's "Abuse or Suspected Abuse/Neglect of a Resident" policy #005010.00 dated 2012/10/23 states: "When investigation is completed notify POA of outcome of investigation".

Interview with the Executive Director and Administrator revealed that the home had failed to notify the residents substitute decision-maker of the outcome of the investigation. The Administrator confirmed the expectation that when the investigation is completed the substitute decision-maker is to be notified of the outcome of the investigation. [s. 97. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Observations on September 8, 2014 revealed a bin containing packages and containers of discarded medications in a locked storage room.

The home's "Drug Destruction and Disposal" policy #5-4 states: "All medications which are surplus, excluding Monitored Medications (narcotic or controlled drugs), are destroyed by the team of nursing staff and one other staff member appointed by the Director of Nursing. Monitored Medications are destroyed by the team of physician or pharmacist and a nursing staff delegate. Medications are considered destroyed when they are altered in a safe and environmentally appropriate manner, using a contracted licensed medical waste disposal service.
4. Medications for destruction are removed from all medication storage areas and retained in a secure area in the medication room, separate from medications for administration to a resident, until such time as they are transferred to the designated Stericycle box/container for destruction and disposal. A surplus medications log (drug destruction and disposal log for non-narcotic and controlled medications) may be used to track additions to the box as per specific home policy.
5. On a routine basis (monthly at minimum), medications for destruction are transferred from the separate storage area in the medication room to a designated stericylce box/container by the team of a nurse and another staff member and documentation of the the date and unit the medications are from are signed off in a log book by both team members. Destroy medications so that their consumption is rendered impossible or improbable (i.e. by covering with a small amount of liquid or cream)."

The Director of Nursing Care confirmed the expectation medications are to be destroyed/denatured by a team of nursing staff in the home by pouring water on them. Interview with the Director of Nursing Care and the Assistant Director of Care revealed that the home does not destroy or denature non-controlled medications; they are picked up in their intact form by Stericycle. [s. 136. (6)]

WN #10: 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 and control program.

Observation of the lower level Tub room (D unit) on September 2, 2014 revealed one unlabeled brush with hair in it was sitting on a shelf. A Personal Support Worker confirmed that the brush should not be left in the tub room.

Observation of the first floor Tub Room on September 2, 2014 revealed one used and unlabeled container of Infazinc 15% zinc Oxide cream and two used and unlabeled hair brushes. The Assistant Director of Care confirmed the hair brushes and cream should not be left in the Tub room and it was discarded.

Observation of a resident shared bathroom counter on September 4, 2014 revealed one used and unlabeled hairbrush and one used and unlabeled deodorant stick. A Personal Support Worker confirmed the hairbrush and deodorant should not be there and it was removed.

The Assistant Director of Care confirmed that all resident personal hygiene items are to be labeled and stored in residents' personal baskets.

Observation of a shared bathroom on September 9, 2014 revealed the call bell cord with clip lying on the bathroom floor. A Personal Support worker confirmed the call bell should not be on the floor and picked it up and wrapped it around the grab bar without disinfecting the cord and clip. [s. 229. (4)]

2. The licensee has failed to ensure that staff are 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 the home's "Tuberculosis (TB) Screening and Mantoux Testing" Policy # 003050.00 states: "All staff must have the following: A two-step TB skin test, ideally before starting to work or within 14 days of beginning work. If the staff member has: A negative TB skin test that was done in the last 12 months, then only a single TB test is required. A previously documented negative two-step TB skin test with the last step more than 6 months ago, then only a single TB test is required."

Review of three employee immunization records revealed there is no documentation to support staff received a TB skin test on hire as per policy and best prevailing practices.

Interview with the Assistant Director of Nursing confirmed staff did not receive a TB skin test as per policy and best practice and confirmed the expectation that all staff receive TB skin test on hire. [s. 229. (10) 4.]

Issued on this 18th day of September, 2014

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