Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 7, 2014	2014_200148_0011	O-000206-14	Resident Quality Inspection

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET, CORNWALL, ON, K6J-5V8

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

SANDFIELD PLACE
220 EMMA STREET, CORNWALL, ON, K6J-5V8

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

AMANDA NIXON (148), BARBARA ROBINSON (572), SUSAN WENDT (546)

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): March 24-28 and March 31 - April 1, 2014, on site.

Two Critical Incidents were included in this inspection, #2778-000005-13 (Log O-001003-13) and #2778-000002-14 (Log O-000167-14).

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), the Activity/Volunteer Supervisor, Registered Dietitian (RD), Unit Clerk, Administrative Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers (FSW), family members and residents.

During the course of the inspection, the inspector(s) reviewed several resident health care records, including plans of care, medication and treatment records and PSW care flow sheets. Several home policies were reviewed including the home's policy to promote zero tolerance of abuse, policies related to the wound care program, the infection control program and the medication management system. Documents related to the activity and recreation program and the management of trust accounts and related agreements were also reviewed. In addition, the inspection include observations of resident care and the provision of meal service.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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 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 comply with O. Reg. 79/10, s. 8 (1) (b), whereby the licensee

did not ensure that the plan, policy, protocol, procedure, strategy or system related to the skin and wound care program was complied with.

In accordance with O. Reg. 79/10 s. 30 (1) 1. and O. Reg. 79/10 s.48 (1) 2., the licensee is required to have a skin and wound care program that includes a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

The home's policy #4.16.1 was last updated October 2010 and describes the home's skin and wound care program. The policy states that all residents will have preventative skin measures evaluated and documented by conducting the Braden Scale for Predicting Pressure Sore Risk and that the care plan will be updated. The policy states that residents with Stage 1 pressure ulcers will have interventions and outcomes documented which includes updating the care plan. The policy further states that residents with Stage 2 pressure ulcers will have documentation of the Braden scale and weekly assessments that include stage, location, odour, and condition of skin.

As confirmed by registered nursing staff, resident #156 has a pressure ulcer located on an identified site. The health care record was reviewed and inconsistencies were found in the MDS, plan of care, and progress notes related to the staging of the wound (Stage 1 or Stage 2) over the past six months. Outcomes related to the provision of treatments, as ordered for the pressure ulcer over the past six months, were not documented. In addition, there was no documentation to support that a Braden Scale had been completed for this resident and there was no documentation to support that weekly assessments were completed that included the stage, location, odour, and condition of skin, as per the home's policy.

As confirmed by registered nursing staff, resident #178 has a pressure ulcer located on an identified site. The health care record was reviewed and inconsistencies were found in the MDS, plan of care, and progress notes related to the staging of the wound (Stage 1 or Stage 2) over the past six months. Outcomes related to the provision of treatments, as ordered for the pressure ulcer, over the past six months, were not documented. In addition, there was no documentation to support that a Braden Scale had been completed for this resident and there was no documentation to support that weekly assessments had been completed that included the stage, location, odour, and condition of skin, as per the home's policy.

RN #S107 stated that his/her role as the Skin Care Coordinator only involves residents who have Stage 3 and 4 pressure ulcers. Registered nursing staff are responsible for the assessment, monitoring, and documentation of Stage 1 and 2 pressure ulcers. The DOC confirmed on March 28, 2014 that at this time neither the Braden Scale nor ongoing assessments for Stage 1 and Stage 2 pressure wounds are being completed. (572)

2. The home's policy further describes that all Stage 3 and 4 pressure ulcers will be assessed and a Braden Scale completed, along with a weekly assessment that includes documentation of stage, location, size, odour, sinus, tracts, exudates and condition of base and surrounding skin.

A review of resident #171's health care record indicated that weekly assessments, related to the resident's Stage 4 pressure ulcer, have not been completed. Inspector #148 spoke with RPN #S107, who is responsible for the weekly assessments of Stage 3 and 4 wounds and he/she indicated that due to the recent disease outbreak in the home, the assessments for the past 2 weeks were not completed. She reported that an assessment is scheduled for the current week.

A progress note on a specified date, by RN #S120, indicated that resident #171 has a second open pressure ulcer at an identified site, a treatment plan was put into place that included spray, dressing and daily monitoring. The resident's health care record was reviewed and the plan of care and electronic Treatment Administration Records (e-TAR) supported that the pressure ulcer and corresponding treatment, were present for a period of 3 weeks, after identified by RN #120.

There was no documentation to support that a Braden Scale had been completed for the second open pressure ulcer and there were no documentation to support that weekly assessments were completed that included the documentation of stage, location, odour, and condition of skin for the current Stage 2 pressure ulcer, as per the home's policy.

In addition, the inspector interviewed RN #S100 and a PSW who regularly cares for resident #171, neither staff member could recall the resident having a second open wound at the identified site. The Inspector interviewed RPN #S101, who could not recall this resident having a second open wound at the identified site. Inspector #148 interviewed the RPN #107 responsible for the assessment of stage 3 and 4 wounds,

who reported that he/she was not aware of the second open pressure ulcer.

The e-TAR indicates that the treatment of spray and dressing was provided for a 3 week span of time after the identification of the open area by RN#120. Three registered nursing staff including RN #S100, RPN #S101 and RPN #107, who had all signed off that the treatment had been provided during the 3rd week, had no recollection of resident #171 having a second open wound at the identified site. RN#S 100 and RPN #S101 were questioned about the provision of this treatment; neither staff member could provide clarity as to why the treatment had been signed off as provided, when they were unaware the open area had existed.

Further to this, interviews with both RN #S100 and RPN #S101 indicated that treatments such as barrier creams and sprays, are provided to the resident by the PSWs in the home. Both staff reported that registered nursing staff are to confirm with the PSWs that the treatment(s) have been provided and then sign the e-TARs indicating that the treatment has been provided.

When interviewed by the Inspector, the home's DOC indicated that PSWs are authorized to provide treatment creams to residents and that PSWs are not authorized to provide treatments such as sprays or dressings. The DOC reported that it is the registered nursing staff who are responsible for such treatments.

The provision of treatment to resident #171's second open wound did not follow the home's protocol, as described by the DOC. The interviews above indicate that the treatment for resident #171 was not documented accurately and potentially not provided to the resident. In addition, assessments were not completed and/or documented for either of the two open pressure ulcers described for this resident, as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)] (148)

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 comply with home policies related to the wound care program are complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 9(1) 1. iii., whereby the licensee did not ensure that all doors leading to the outside of the home are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The home was found to have three exit doors leading to the outside: one at the front entrance of the home; one at the end of the Forget Me Not care unit; and one at the end of the Ivy care unit. Each of the three exits includes two sets of doors, described here as an inner door and outer door.

On March 26, 2014, Inspector #148 reviewed all three exit doors leading to the outside of the home. At the front exit of the home, the inner door is kept closed and locked and is equipped with a door access control system; the outer door is kept closed but is not locked or equipped with a door access control system. At the exit located at the end of the Forget Me Not care unit the inner door is kept closed and locked and is equipped with a door access control system; the outer door at this location is kept closed but is not locked or equipped with a door access control system. At the exit located at the end of the Ivy care unit the inner and outer door are kept closed and locked and are equipped with a door access control system. It was demonstrated by Inspector #148 that none of the identified doors above that lead to the outside of the home were equipped with an audible door alarm. Each of the doors described above were held open for 3-5 minutes with no evidence of an audible alarm.

On March 27, 2014, Inspector #148 spoke to the home's Administrator and Director of Care, both of whom indicated that no door in the home, including those doors described above that lead to the outside of home, are equipped with an audible door alarm.

At the time of this inspection, no door leading to the outside of the home was equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and that is connected to the resident-staff communication and response system or is connected to an audio visual enunciator that is connected the nurses' station nearest to the door and has a manual reset switch at each door.

It is noted that section 9(1)1 iii, does not apply to the two exits leading to the secure outside area of the home. [s. 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 doors leading to the outside of the home are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and that is connected to the resident-staff communication and response system or is connected to an audio visual enunciator that is connected the nurses' station nearest to the door and has a manual reset switch at each door, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.30 (1) 3., whereby the licensee did not ensure the skin and wound care program is evaluated and updated at least annually in accordance with evidence based practices and, if there are none, in accordance with prevailing practices.

In accordance with O.Reg 79/10, s.30 and s.48 (1) 2., the licensee shall ensure that there is an interdisciplinary skin and wound program to promote skin integrity, prevent the development of wounds and pressure ulcers and provide effective skin and wound care interventions. The skin and wound program shall be evaluated and updated at least annually and a record shall be kept of each evaluation.

During a review of the skin and wound care program, it was found that the program policies in place do not reflect the home's current practice. This is exampled by the policies lacking any mention of the Pixalere database that has been used in the home for the assessment and monitoring of Stage 3 and Stage 4 wounds, since July 2013. In addition, a policy written to describe the provision of creams and lotions by PSWs indicates that the provision of such treatments will be provided to the resident and the provision documented by the PSW. The DOC confirmed that this policy reflects the program when it included hard copy treatment records. The home has been using electronic treatment records for approximately 3 years, in which only registered nursing staff document the provision of all treatments.

In addition, during the course of this inspection, non-compliance was identified as it relates to the implementation of the skin and wound care program under both section 6 of the Act and section 8 of the Regulations. Findings reflect that the policies are not adhered to by staff and/or that management is aware that current practices are not reflected in the program policies.

On April 3, 2014 the home's Administrator and DOC reported to Inspector #148 that the nursing program manual, containing policies related to several nursing care programs, was last reviewed November 2013. A document was provided that indicated all contents of the manual had been reviewed by the DOC on November 2013. It has been demonstrated that the skin and wound program has not been evaluated and updated at least annually as per the requirements of section 30 of the Regulations. [s. 30. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the skin and wound care program are evaluated and updated at least annually with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 37 (1) (a), whereby the licensee did not ensure that each resident of the home has his or her personal items labeled within 48 hours of admission and of acquiring, in the case of new items.

The following observations were made between March 24 and 26, 2014:
In an identified shared resident bathroom - observed unlabelled personal items including toothbrushes, razors and deodorant stored in resident labelled bins.
In an identified shared resident bathroom– observed unlabelled personal items including deodorant, hair combs and toothbrushes stored in resident labelled bins.
In an identified shared resident bathroom – observed unlabelled personal items including two unlabelled toothbrushes (held in toothbrush holder) on bathroom counter along with unlabelled black hair brush. Contained within one resident labelled bin, a toothbrush and deodorant were observed without a label.
In an identified shared resident bathroom/bedroom – observed unlabelled personal items including an unlabelled hair comb, hair brush and a toothbrush on the bathroom counter; in addition, an unlabelled toothbrush on the bedside table of bed 1 was observed.
In an identified private resident bathroom/bedroom – observed unlabelled personal items including unlabelled toothbrush, hair combs and deodorant on the bathroom counter. A bin labelled with the resident's name was empty.
In an identified private resident bathroom/bedroom – observed unlabelled personal items within the resident's labelled bin including deodorant and hair brush unlabelled; in addition a toothbrush with no label was observed on the bathroom counter.

It was confirmed by the home's Director of Care, that the home's process is to provide each resident with a labelled bin, in which each resident is able to store personal items. The home's process includes labelling of glasses, dentures and hearing aids, however, the home does not currently have a process in place to ensure that each resident's personal items, such as those described above, are labelled in accordance with section 37. [s. 37. (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 each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring , in the case of new items, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 3. (1)11 (iv), whereby the licensee did not ensure that each resident of the home has his or her personal health information kept confidential.

Medication administration for six residents was observed on March 27, 2014. RPN #S117 placed multi-dose medication packages for residents, which identified resident personal health information inclusive of names and names of medications, into a garbage bag attached to the medication cart. RPN #S117 stated that the garbage bag from the medication cart was disposed of with the regular garbage. RPN #S114 and RN #S100 also reported that multi-dose medication packages with resident personal health information are disposed of with the regular garbage.

On March 28, 2014 the DOC stated that she had issued a written change in practice that instructed staff to obscure the resident personal health information by tearing open the multi-dose medication package through the words written on the package. The home's medication policy #3-7 states that empty medication packages can be destroyed with water to remove personal health information. Observations by the inspector confirmed that neither practice is being adhered to by registered staff. [s. 3. (1) 11. iv.]

WN #6: 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. (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 comply with LTCHA 2007, S.O. 2007, c.8, s.6(1)(a), whereby the licensee did not ensure that the written plan of care for each resident sets out the

planned care for the resident.

The most recent Minimum Data Set (MDS) Assessment and Resident Assessment Protocols (RAP), indicated that resident #171 exhibits both verbal and physical aggression during the provision of care. The RAP further describes that the resident is responding to the interventions as outlined in the care plan.

The PSW Flow sheets were reviewed for the current month, which indicates that resident #171 is resistive to care and will exhibit physical and verbal aggression toward staff daily.

Interviews with RN #S100 and PSW #112, both responsible for the resident's care, identified triggers related to the residents verbal and physical aggression and that the behaviour may vary.

The current plan of care for resident #171 includes issues related to the resident resisting care and instructs staff to allow for flexibility in the provision of routine care. The plan of care does not set out any issues with the resident's physical or verbal aggressive behaviours. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6(7), whereby 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.

Resident #171 is at high risk for skin breakdown and currently has a stage 4 pressure ulcer at an identified site. The plan of care for resident #171 indicates that all skin surfaces are to be assessed weekly during bath, results are to be documented and the results of any bruises, reddened areas, open areas or rashes are to be reported. The plan of care indicates that the responsibility is to the PSW to implement this intervention.

Interviews with Registered nursing staff and PSWs responsible for the care of resident #171, report that monitoring of a resident's skin integrity occurs during baths and during the provision of other care, however, there is no formalized process in place for this monitoring and no such assessments or monitoring are documented.

Resident #171 does not have the results of weekly skin assessments, as per the residents' plan of care, documented. [s. 6. (7)]

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 comply with LTCHA 2007, S.O. 2007, c.8, s. 24 (1) 2., whereby the licensee did not ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director.

The Director received a Critical Incident report #2778-000005-13, submitted by the home on a specified date, which described that resident #199 was found wearing an over-saturated incontinence brief with clothing soiled with urine.

The DOC stated that she was aware of the incident and reported the incident to the Administrator on the day the incident occurred. The DOC stated that at that time, both she and the Administrator had reasonable grounds to suspect that neglect of a resident had occurred.

The DOC and Administrator initiated their investigation by interviewing attending staff and requesting written statements. The DOC could not recall if there had been a call or message alerting the Ministry of Health and Long Term Care (Director) of the intended mandatory report. The incident was reported to the Director by the DOC via the Critical Incident System 7 days after the DOC and Administrator had reasonable grounds to suspect neglect. [s. 24. (1) 2.]

WN #8: 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 failed to comply with LTCHA 2007, S.O. 2007, c. 8, s.85 (1), whereby the licensee did not ensure that, at least once in every year, a survey is taken of the resident's and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

The home's administrator reported to Inspector #148 that the home was not aware of the requirement to conduct annual satisfaction surveys. The home has previously planned the satisfaction survey to coincide with the accreditation process that occurs every three years. In this respect, the home has not implemented a satisfaction survey since 2011 and are planning the next satisfaction for the fall of 2014. [s. 85. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.91 (1) 3., whereby the licensee did not ensure a resident shall be charged, only if it was provided under an agreement.

Inspector #148 reviewed the financial data for three (3) residents. The records for Resident #157 indicated that during the current calender year, the resident had been charged for hair dressing, dry cleaning and food care.

Upon further inquiry the home was unable to provide evidence that an agreement existed providing for the above described charges and/or for those charges to be deducted from the resident's trust account. [s. 91. (1) 3.]

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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with the O.Reg. 79/10 s. 229. (10) 3.,whereby the licensee failed to offer residents immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website

Several resident health care records were reviewed which demonstrated that the pneumococcal vaccine is offered to residents; consent and the administration of the pneumococcal vaccine are documented in the resident health care record. There was no documentation to support that residents of the home are offered either the tetanus or diphtheria vaccine.

During an interview with the home's DOC, it was reported that residents are offered the pneumococcus vaccine but not the tetanus and diphtheria vaccines. The DOC added that although this has been tabled at their Professional Advisory Committee, it has yet to be implemented.

At this time the home does not offer resident immunization again tetanus and diphtheria. [s. 229. (10) 3.]

Issued on this 7th day of April, 2014

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

Amanda Nixon, LTCH Inspector