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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 1, 2015	2015_235507_0003	T-1730-15	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

SEVEN OAKS
9 NEILSON ROAD SCARBOROUGH ON M1E 5E1

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

STELLA NG (507), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

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): February 5, 6, 9, 10, 11, 12, 13 and 17, 2015.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection: T- 1161-14, T-1187-14 and T- 1580-14.
The following Critical Incident Intake was inspected concurrently with this Resident Quality Inspection: T- 1252-14.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant administrator (AD), director of nursing (DON), nurse managers (NMs), registered dietitian (RD), nutrition managers, building services manager (BSM), social worker (SW), occupational therapists (OTs), registered staff, personal care aides (PCAs), food service manager (FSM), food service workers (FSWs), housekeeping aide (HA), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors also conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **10 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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. (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).

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

Findings/Faits saillants :

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

Review of the progress notes and Resident Incident Report for an identified resident revealed that an ulcer was documented on an identified date. Review of the Minimum Data Set (MDS) assessment dated four days later revealed that the identified resident did not have a skin ulcer in the past seven days prior to the assessment.

Interview with an identified NM revealed that the MDS assessment should be completed by assessing the resident, reviewing all records of the resident, and gathering input from all staff. The identified NM confirmed that the staff and others involved in the different aspects of care of the identified resident failed to collaborate with each other when

completing the resident's above mentioned MDS assessment. [s. 6. (4) (a)]

2. Interviews with two identified residents revealed that staff are using a bed pan for toileting for three months.

Review of the first identified resident's plan of care indicated that the resident is toileted in the washroom during the day for elimination, and at night the resident is dependent on two staff to change his/her incontinence brief and provide hygiene care.

Review of the second identified resident's plan of care indicated that the resident is transferred on the toilet in the washroom by one staff during the day, and the resident is total dependent on one staff to change incontinence brief and provide hygiene care at night.

Interview with an identified OT indicated that on an identified date, he/she assessed the two identified residents for the use of hygiene sling. He/she recommended for safe toileting to use a hygiene sling with body support for the first identified resident and hygiene sling with head and body support for the second identified resident.

Interview with an identified PCA confirmed that due to the unavailability of the recommended slings, the identified residents are toileted in bed. Interview with the ADOC indicated that alternative slings are available, and confirmed that the use of those slings has not been assessed by the OT and staff needs to be trained prior using them.

The OT confirmed that his/her assessment was not integrated in the above mentioned residents' written plan of care. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

a) Review of an identified resident's MDS assessment on an identified date, indicated that the resident's vision is moderately impaired. Review of the resident's written plan of care on an identified date three months later revealed that the identified resident's impaired vision was not documented in the resident's plan of care.

During the course of the inspection, the inspector observed the identified resident did not

wear glasses.

Interview with the resident's SDM revealed that the resident's vision is impaired, but he/she is no longer interested in wearing glasses.

Interviews with an identified registered staff and an identified NM confirmed that the identified resident's impaired vision was not documented in the resident's plan of care.

b) Review of another identified resident's written plan of care on an identified date indicated that the resident is identified as being at risk for bruising/ skin abrasion, and one of the interventions is to change position every two hours in bed and in chair.

Interviews with two identified PCAs revealed that the resident was to be repositioned when he/she requested while in chair, and when awake while in bed as per resident's preference. Interviews with two identified registered staff confirmed that they were not aware of the resident's preference when the resident's plan of care was being developed. [s. 6. (4) (b)]

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

a) Review of the physician's order for an identified resident revealed that the resident's three stage 2 ulcers were to be cleansed and apply dressings every two days and as needed with a start date of an identified date.

Review of the Treatment Administration Record (TAR) and interviews with an identified registered staff and an identified NM confirmed that the dressing changes to the ulcers were not documented on three identified dates.

b) Review of another identified resident's TAR revealed that one of the resident's wounds required cleansing and dressing for a period of three weeks. Record review and interviews with two identified registered staff confirmed that the dressing to the resident's wound was not documented on four identified dates.

Review of the identified resident's TAR revealed that the resident's another wound required daily treatment for a period of six weeks. Record review and interviews with two identified registered staff confirmed that the treatment was not documented on 12 identified dates. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident’s care needs change.

Interviews with identified PCAs and registered staff confirmed that an identified resident was able to follow simple verbal instruction in performing his/her oral care prior to the hospitalization for a period of seven days. Interviews with identified staff revealed that after his/her return to the home, the identified resident's Activity of Daily Living (ADL) ability declined and now requires total dependence for his/her oral care.

Review of the identified resident’s written plan of care on an identified date after the return from the hospital, indicated that the resident required one-staff assistance in setting up mouth care tools, and during mouth care staff to initiate brushing for the resident and the resident to resume with staff cueing until completion.

Interviews with an identified registered staff and an identified NM confirmed that the identified resident’s plan of care was not updated when the resident’s care needs changed. [s. 6. (10) (b)]

6. A review of the written plan of care for an identified resident revealed that eyeglasses are required for impaired vision.

On three identified dates, the inspector observed the identified resident did not wear eyeglasses.

Interview with an identified registered staff revealed that the family had taken the eyeglasses home a year ago as the identified resident was not wearing them anymore.

Interview with an identified PCA and an identified registered staff confirmed that the identified resident has not worn eyeglasses for impaired vision for a year and that the written plan of care had not been reviewed and revised accordingly. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the ensure that:
1. the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
2. the staff and others involved in the different aspects of care of the resident collaborate with each other 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,
3. the provision of the care set out in the plan of care is documented, and
4. the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, and when care set out in the plan of care is no longer necessary, 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Record review revealed that an identified resident was sent to the hospital on an identified date and returned to the home on the same day. Two months later, the resident was sent to the hospital for a period of 10 days.

Record review and interviews with two identified registered staff confirmed that skin assessments had not been completed upon the resident's return from hospital on the above mentioned two occasions. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Review of the progress notes for an identified resident revealed that the resident is identified as being at risk for bruising/ skin abrasion. On an identified date, an open wound with drainage was documented. Review of the TAR revealed that intervention to the ulcer did not commence until six days later.

Interviews with two identified registered staff confirmed that the resident did not receive immediate interventions to promote healing, and prevent infection to his/her ulcer as required. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

A review of an identified resident's health record revealed that the resident has a stage 2 pressure ulcer for 15 months.

Record review and interview with the RD confirmed that a nutritional assessment was not completed by the RD related to the pressure ulcer. [s. 50. (2) (b) (iii)]

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

Review of the home's Skin Care and Wound Preventive and Management policy, reference # RC-0518-02, revised October 1, 2010, indicates that registered staff are required to reassess weekly for any evidence or risk of altered skin integrity.

a) Review of the progress notes of an identified resident revealed that three stage 2 ulcers were documented on an identified date.

Record review of the Weekly Ulcer/ Wound Assessment Record revealed and interviews with identified registered staff confirmed that skin assessments were not completed on

two of the resident's ulcers on three identified weeks. Skin assessments were not completed on the resident's third ulcer on two identified weeks.

Interview with an identified NM confirmed that skin assessments should have been completed for all ulcers weekly.

b) Record review revealed that an identified resident is identified as being at risk for bruising/ skin abrasion. Review of the progress notes revealed that the following altered skin integrity was documented:
- On an identified date, an open wound with drainage was documented on, and the wound was healed two and a half months later.
- On another identified date, two skin tears were documented on, and the skin tears were healed three weeks later.
- On a third identified date, blisters were documented on.

Record review and interviews with two identified registered staff confirmed that weekly skin assessments have not been completed for the above mentioned skin conditions. [s. 50. (2) (b) (iv)]

5. A review of health record reveals that an identified resident has a stage 2 pressure ulcer for 15 months.

Record review and interview with an identified registered staff confirmed that weekly wound assessments were not completed on two identified weeks for the resident. [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 at risk of altered skin integrity:
1. receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital,
2. receives immediate treatment and interventions to reduce o relieve pain, promote healing, and prevent infection, as required,
3. is assessed by a registered dietitian who is a member of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
4. is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: 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 the home's Skin Care and Wound Prevention and Management policy is complied with.

Review of the home's Skin Care and Wound Preventive and Management policy, reference # RC-0518-02, revised October 1, 2010, indicates that a Branden Scale is to be completed for all ulcers, skin tears or wounds.

Record review revealed that an identified resident is identified as being at risk for bruising/ skin abrasion. Review of the progress notes revealed that the following altered skin integrity was documented:
- On an identified date, an open wound with drainage was documented on, and the wound was healed two and a half months later.
- On another identified date, two skin tears were documented on, and the skin tears were healed three weeks later.
- On a third identified date, blisters were documented on.

Record review and interviews with two identified registered staff confirmed that Braden Scale has not been completed for the above mentioned skin conditions as required. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Skin Care and Wound Prevention and Management policy is in compliance with all applicable requirements under the Act.

Regulation section 50(2)(a)(ii) states that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

The home's Skin Care and Wound Prevention and Management policy, reference # RC-0518-02, revised October 1, 2010, indicates that registered nursing staff are required to conduct a head-to-toe assessment of skin, feet and mouth when a resident returns from hospital after an absence greater than 24 hours. This policy is not in accordance with the regulation that states a registered nursing staff is to conduct a skin assessment upon any return of the resident from hospital, and does not refer to when the absence is greater than 24 hours. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's Routine Practices policy is complied with.

Review of the home's Routine Practices policy, reference # IC-0501-00, revised April 1, 2010, indicates that hand hygiene is required before/ after any direct contact with a resident, between residents.

On an identified date, the inspector observed an identified registered staff did not perform hand hygiene prior to administrating medication to an identified resident on an identified unit.

Interview with the identified registered staff confirmed that he/she did not perform hand hygiene prior to administrating medication. [s. 8. (1)]

4. The licensee has failed to ensure that the home's Off-Hours Medication Supply policy is complied with.

Review of the home's Off-Hours Medication Supply policy, reference #PH-0109-00, revised June 1, 2012, and interviews with an identified registered staff and an identified acting NM confirmed the following procedures are required when taking medications from the emergency starter box and replacing them:
• When the required medication is removed from the supply cupboard during off-hours, the resident's name and room number should be written on off-hours drug stock label.
• The Off-Hours Medication Supply Control Sheet is to be completed including:
 o Date and time starter pack removed;
 o Name and strength of drug;
 o Quantity taken;
 o Quantity remaining;
 o Resident's name; and
 o RN/RPN signature.
• The label from the Medication Starter Pack is peeled and placed in the Drug Record Book, and the full order to the Drug Record Book is transcribed.
• The page of the Drug Record Book is faxed to pharmacy together with the carbon of the physician's order.
• Medications will be replenished by the next business day by the Pharmacy.

Review of the home's Off-Hours Supply Control Sheet and interview with the identified registered staff confirmed that the quantities of keflex 250 mg, cipro 250 mg and septra 400/80 mg in the emergency starter box should be 4x8 for each of the above mentioned medication at all times.

On an identified date, the inspector and an identified registered staff observed the following medications listed on the Off-Hours Medication Supply Control Sheet were not included in the emergency starter box:

1. keflex 250mg (3x8)
2. cipro 250mg (1x8)
3. septra 400/80mg (1x8)

Review of the Emergency Starter Box Monitoring Form revealed the above mentioned medications were not included in the emergency starter box according to the Off-Hours medication Supply Control Sheet six days earlier.

Interviews with the identified registered staff and the acting NM confirmed that the above mentioned medications were not replaced according to the policy. [s. 8. (1) (b)]

5. The licensee has failed to ensure that the home's Handling Leftovers policy is complied with.

Review of the home's Handling Leftovers policy revised September 1, 2013, indicated that staff should cover and label food with the date and time when food was prepared, and should discard leftovers that are stored in refrigerator and not used within 72 hours,

On two occasions the inspector observed containers of thickened milk stored in the fridge 72 hours after the first day it was prepared.

On an identified date, the inspector observed the labels on the thickened milk containers were dated four days prior, and two weeks later.

Interview with an identified FSW indicated that he/she dates the left over thickened milk based on the milk package expiry date. Interview with the FSM confirmed that all leftovers should be discarded 72 hours after the first day of preparation to eliminate risk related to food borne illness that caused by feeding residents with expired food and fluid. [s. 8. (1) (b)]

WN #4: 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's furnishings are kept clean and sanitary.

On two identified dates, the inspector observed the dining room chairs in an identified dining room to be stained and soiled with food debris.

Interview with an identified FSW confirmed that the chairs are stained. [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of health conditions, including pain with respect to the resident.

Record review of the MDS assessment on an identified date indicated that an identified resident has moderate pain. Review of the progress notes indicated that the resident has complained of pain on six identified dates.

Interview with the resident's family confirmed the resident complains of pain frequently. Review of the resident's written plan of care indicated that pain has not been included.

Interview with the DON confirmed that pain should be included in the resident's written plan of care. [s. 26. (3) 10.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed by the method of his or her choice, unless contraindicated by a medical condition.

Interviews with two identified residents revealed that both residents preferred method of bathing is shower. The identified residents confirmed that they have not been given a shower for a period of four months; instead they are receiving a bed bath twice weekly. They were told that the shower was suspended temporary related to the safe use of hygiene sling, and both residents were referred to the OT.

Record review indicated that preferred method of bathing for the first identified resident is shower using a tilt reclining shower chair, and for the second identified resident is shower using an upright shower chair. On an identified date, the inspector observed tilt reclining shower chair and an upright shower chair in the shower room.

Interviews with identified PSWs and registered staff confirmed that the two identified residents have not received a shower for a period of four months, because they are waiting for the hygiene sling with body and head support recommended by the OT to resume the shower, and indicated that alternate sling available in the home for transferring from bed to chair are not appropriate for shower.

Interview with the ADOC confirmed that above mentioned residents should be showered and indicated that the home has alternative slings that can be used for transferring to the shower chair. [s. 33. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training and retraining in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act annually.

Review of staff education record revealed and interview with the DON confirmed that 10 per cent of all staff did not receive training in infection prevention and control in 2014. [s. 76. (4)] [s. 76. (4)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted as required.

On February 5, 2015, the inspector observed the following inspection reports were not posted in the home:
- 2013_049143_0032 dated June 3, 2013
- 2013_049143_0033 dated June 3, 2013
- 2013_162109_0034 dated October 21, 2013

The absence of the above mentioned inspection reports was confirmed in an interview with the administrator and assistant administrator. [s. 79. (3) (k)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive skin and wound care training.

Review of training record and interview with the DON confirmed that 30 per cent of all staff who provide direct care to residents did not receive skin and wound care training in 2014. [s. 221. (1) 2.]

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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the Toronto Public Health recommendations for Tuberculosis (TB) Screening in Long Term Care (LTC) and Retirement Homes updated on February 14, 2013 revealed that Tuberculin skin tests (TST) are not recommended to be done upon admission for residents 65 years of age or older and a review of the Canadian TB Standards, 6th edition (CTS 2007) advises that residents 65 years of age and older of LTC Institutions undergo baseline posterior-anterior and lateral chest x-rays.

Review of health records revealed that two identified residents who are older than 65 years of age and were admitted in 2014, were screened using the 2-steps TB-screening upon admission. Review of the home's Tuberculosis Screening policy IC-0303-00 updated on April 1, 2013, and interview with the DON confirmed that all residents are screened with 2-steps Mantoux test upon admission.

Interview with the representative from Toronto Public Health TB Prevention Program indicated that all LTC homes within Greater Toronto Area (GTA) are expected to follow the above mentioned recommendations.

Record reviews and interview with the DON confirmed that the home's Infection Prevention and Control Program is not in accordance with evidence-based or prevailing practices. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participate in the implementation of the

infection prevention and control program.

On an identified date, the inspector observed in two identified shared bathrooms, four unlabeled used toothbrushes and three unlabeled used denture cup containers.

Interviews with an identified registered staff and an identified NM confirmed that all resident personal oral care items are to be labeled with the residents name. [s. 229. (4)]

3. On an identified date, the inspector observed the following opened and unlabeled personal care items in an identified shower/tub room:

- shaving cream,
- three disposable razors,
- three tooth brushes, and
- one hair brush with hair.

Interviews with an identified PCA and an identified registered staff confirmed that the supplies are available for the residents who do not have their own labeled personal items, and they failed to verify the above mentioned items are brand new. [s. 229. (4)]

Issued on this 9th day of April, 2015

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

Original report signed by the inspector.