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
Jun 12, 2014	2014_263524_0017	L-000556-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF WATERLOO
150 Frederick Street, KITCHENER, ON, N2A-4J3

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

SUNNYSIDE HOME
247 FRANKLIN STREET NORTH, KITCHENER, ON, N2A-1Y5

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

INA REYNOLDS (524), MELANIE NORTHEY (563), NANCY JOHNSON (538)

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): May 20, 21, 22, 23, 26, 27, 2014.

During the course of the inspection, the inspector(s) spoke with the Director, Acting Administrator(s), Environmental and Food Services Manager, Food Services Supervisor, Environmental and Maintenance Services Superintendent, Restorative Care Supervisor, Infection Control Coordinator, Education Coordinator, Administrative Assistant,
Pharmacist, 7 Registered Nurses, 4 Registered Practical Nurses, 9 Personal Support Workers, 1 Cook, 2 Dietary Aides, 1 Maintenance Staff, Resident’s Council President, Family Council President, 31 Residents and 3 Family members of the Residents.

During the course of the inspection, the inspector(s) toured all resident home areas, observed meal service, medication passes, medication storage areas and care provided to residents, resident/staff interactions, infection prevention and control practices, reviewed medical 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, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

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

Observation of an identified resident's bed on May 23, 2014 revealed two bed rails in the up position. Review of the clinical record on May 23, 2014 revealed "one bed rail up on the right side of the resident's bed facing the window."

Interview with the resident on May 23, 2014 revealed that it is the resident's personal preference that both bed rails are in the up position to allow for easier transfer in and out of bed.

Interview with the Team Lead, Registered Nurse on May 23, 2014 confirmed that it is the home's expectation that the plan of care provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (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 written plan of care set out clear directions to staff and others who provide direct care to the resident, 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 failed to ensure that the "Fall Prevention Program" policy (Number:

f-01) instituted or otherwise put in place is complied with.

Review of the "Falls Prevention Program" policy (Number: f-01) dated August 18, 2013 revealed: "A resident who is deemed to be high risk will have an orange laminated leaf placed on their door and mobility device that would alert staff of their potential high risk for falls. A Resident with a High risk score of 10 or greater on the Falls Risk Assessment Tool (FRAT) or any resident who has had 2 or more falls in the past month will have a leaf placed on their door to flag staff of the high risk of falls. If the resident goes one quarter without a fall, the resident is discharged from the Falling Leaf Program."

On May 23, 2014, record review of an identified resident revealed the resident had two falls in a month and had a high risk score on the Fall Risk Assessment indicating the resident is at high risk for falls. Observation of the resident's room revealed that there was no orange leaf outside the resident's room.

The Registered Practical Nurse confirmed that this resident was at high risk for falls and should have had an orange leaf outside their door as identification that the resident is at risk for falls. The Registered staff confirmed that there was no orange leaf outside the resident's room.

On May 23, 2014, record review of an identified resident revealed the resident had a high risk score on the most recent Fall Risk Assessment. Observations of the resident's room revealed that there was no orange leaf outside the resident's room.

The Acting Administrator stated the Falling Leaf Program is under review. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the "Building and Resident Security" policy (Number: B-50) instituted or otherwise put in place is complied with.

Review of the "Building and Resident Security" policy (Number: B-50) revealed Interior doors general to staff only areas are described as "Interior doors which transition from resident/general areas to staff only areas, such as Spa and Staff corridor areas." These doors are activated by a card reader.

Observation of home care areas on May 20, 2014 during the initial home tour revealed the spa doors did not auto lock in three home areas.

Three Personal Support Workers confirmed spa doors should be locked at all times and demonstrated that the doors did open without card reader access. A Personal Support Worker in each home area called maintenance for immediate follow-up. [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 the 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation of a resident on May 21, 2014 revealed resident was verbally calling for staff and call bell was not within reach. The resident was sitting in a wheelchair to the right of the bed near the window and the call bell was under the bedding on the right side of the bed and out of sight.

Observation of a resident on May 21, 2014 revealed resident was verbally calling for staff and call bell was not within reach. The resident was sitting in a wheelchair to the left of the bed near the window and the call bell was under the bedding on the left side of the bed and out of sight.

Both residents demonstrated that they knew how to use the call bell when it was placed in their hands.

Staff interview with Registered Practical Nurse in the home care area on May 21, 2014, revealed the home's expectation is that resident call bells are to be within reach at all times when resident is in their room. Call bells can also be attached to the resident while in bed or wheelchair or placed in the resident's hand. Nursing staff can also assess call bell ability on admission and thereafter when there has been a change in condition. [s. 17. (1) (a)]

2. The licensee failed to ensure that the resident-staff communication and response system is available at each bed, toilet, bath and shower location used by residents.

Observation of an identified resident's bathroom revealed call bell was non-functional. The call bell was tightly wrapped around the frame on the left side of the toilet preventing the resident from activating the communication system.

Staff interview with the Team Leader, Registered Nurse for the home care area on May 26, 2014 revealed call bells are not to be wrapped around the grab bars or frames in the residents bathrooms.

Team Leader, Registered Nurse, called maintenance immediately for follow-up. A member of the maintenance staff tested the call bell in the resident's bathroom and confirmed it was very difficult to engage alarm due to the cord being tightly wrapped around the frame. The cord was removed from the frame, and the connector clasp was replaced on the call bell cord and the call bell was then functional. [s. 17. (1) (d)]

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 the resident-staff communication and response system is available and can be easily seen, accessed and used by residents, staff and visitors at all times, 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident’s physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Record review for a home care area on May 27, 2014 revealed three identified residents did not have a "Record of Consent to Restraints or PASD" signed and in their charts.

Staff interview with the Registered Practical Nurse revealed all residents using a restraint or PASD must have informed consent signed and in the chart. The Registered Practical Nurse confirmed there was no consent obtained for the three identified residents. [s. 33. (4) 5.]

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 use of a PASD under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied: the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

Record review of the weekly assessments in the progress notes for three identified residents revealed that the residents' altered skin integrity was not consistently reassessed at least weekly.

The Acting Administrator confirmed it is the home's expectation that registered staff complete weekly assessments for all residents exhibiting altered skin integrity. [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 the 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, to be implemented voluntarily.

WN #6: 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.

Record review of the “Sunnyside Home Weights and Vitals Summary” on May 22, 2014 revealed 152 residents did not have a height measurement between May 21, 2013 and May 21, 2014.

Staff interview with Registered Practical Nurse in the home care area on May 21, 2014 confirmed all residents are to be measured for height annually.

Staff interview with the Acting Administrator on May 22, 2014 revealed the home's expectation is that all residents heights are to be measured on admission and annually. [s. 68. (2) (e)]

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 #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

Medication administration observation on May 22, 2014 where by the Register Practical Nurse in a home care area left the medication cart several times unlocked with the third drawer slightly opened and the keys on the top of the medication cart. The medication cart was parked outside the dining room area out of reach and out of sight while the Registered Practical Nurse walked to the back of the dining room.

The Registered Practical Nurse from the home care area confirmed the medication cart should be locked at all times when the cart is no longer within eyesight of the registered staff.

The Acting Administrator confirmed it is the home's expectation to lock the medication cart at all times when unattended. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Interview with an identified resident on May 21, 2014 revealed the resident keeps medication in their possession for use.

Record review of physician orders for the resident revealed that the medication order did not include the physician's approval for self administration.

Interview with the Registered Practical Nurse on May 21, 2014 revealed staff was unaware that the resident had the medication in their possession and the Registered Practical Nurse confirmed on May 22, 2014 that the medication was removed from the resident. The Registered Practical Nurse completed a physician referral to review self administration for the resident at physician's next visit. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #9: 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,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that the interdisciplinary team that co-ordinates and implements the infection prevention and control program meets at least quarterly.

Interview with the Infection Control Coordinator on May 22, 2014 revealed that the home has an Infection Control and Prevention Committee that is to meet quarterly during the months of September, December, March and June.

The Infection Control Coordinator confirmed that the last meeting held was on January 3, 2014 and that there was not a committee meeting held during the month of March 2014. [s. 229. (2) (b)]

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

Observation during initial tour of a home care area on May 20, 2014 revealed: Residents medical equipment was sitting on an arm chair and another sitting on the floor near the nursing station. Personal Support Worker confirmed the medical equipment should be properly stored and not lying on the floor.

Observation of bathing areas in the home care areas on May 20 and 21, 2014 revealed:
Spa room 1: one used and unlabeled denture toothbrush, hair brush, bottle of hand and body lotion, and one pair of used and unlabeled nail clippers.

Spa Room 2: one used and unlabeled bar of soap, tube of gel, tube of toothpaste, tube of barrier cream, and 8 sets of used and unlabeled nail clippers.
Washroom area 2: three used and unlabeled tubes of toothpaste and 2 used and unlabeled bottles of mouthwash
Shower room 2: one used and unlabeled tube of barrier cream.

Spa room 3: one used and unlabeled bottle of hand and body lotion
Washroom area 3: two used and unlabeled tubes of barrier cream, one used and unlabeled tube of toothpaste
Shower area 3: three sets of unlabeled nail clippers and one used and unlabeled tube of barrier cream.

Observation of medication cart in a home care area on May 22, 2014 revealed one used and unlabeled tube of barrier cream located in the bottom drawer of the medication cart. Registered Nurse confirmed it should be labeled with the appropriate resident’s name. The Registered Nurse removed the barrier cream and disposed of it immediately.

Medication administration observation of the Registered Practical Nurse in a care area on May 22, 2014 revealed the Registered Practical Nurse touched a resident's face during medication administration and wiped under resident's eyes with a tissue. No hand hygiene was done between residents during the medication administration observation.

On May 20, 2014, two used unlabeled combs, a tube of toothpaste and a bottle of cream was found on the counter of a shared resident bathroom. A Personal Support Worker confirmed that these items should not be there and are now unusable. An unlabeled wash basin was also found on the floor of the shared bathroom. This was confirmed by the Personal Support Worker.

On May 20, 2014, an unlabeled toothbrush and nail polish remover was found in a resident bathroom. This was confirmed by two Personal Support Workers who shared

they are responsible for labeling all resident personal hygiene items.

On May 21, 2014, an unlabeled used hair brush was observed on the counter of a shared bathroom. This was confirmed by a Personal Support Worker.

On May 22, 2014, a used bar of soap was found in a tub room. This was confirmed by a Personal Support Worker.

On May 23, 2014, three unlabeled toothbrushes were observed on the counter of a shared resident bathroom. This was confirmed by the Registered Practical Nurse.

May 22, 2014, the Infection Control Coordinator shared that staff are responsible for labeling all Resident personal hygiene items despite the type of accommodation the Resident resides in. [s. 229. (4)]

3. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

A review of the immunization records for two identified residents revealed that not all residents were screened for tuberculosis within 14 days of admission or within 90 days prior to admission to the home.

This was confirmed by the Infection Control Coordinator on May 22, 2014. [s. 229. (10) 1.]

4. The licensee failed to ensure that all pets visiting as part of a pet visitation program have up-to-date immunizations.

Interview with the Staff Education Coordinator on May 26, 2014 revealed that the home was unable to provide up-to-date immunization records for all pets visiting as part of the pet visitation program.

The Acting Administrator and Staff Education Coordinator confirmed that it is the home's expectation that all pets visiting as part of a pet visitation program have up-to-date immunizations. [s. 229. (12)]

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 interdisciplinary team that co-ordinates and implements the program meets at least quarterly, that all staff participate in the implementation of the infection prevention and control program, that all pets visiting as part of a pet visitation program have up-to-date immunizations, and that immunization and screening measures are in place, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a good state of repair.

Observation of home care areas on May 20 and 21, 2014 revealed the following:
-paint was chipped around several identified common areas and residents bedrooms and bathrooms
-hand rails were chipped, scraped and peeling
-a resident bathroom had two holes in the wall where hooks were previously placed; the holes were not filled or repaired
-Spa Room had one lower cabinet door hanging from its hinge
-soap dispenser broken in a resident bathroom
-rust areas on floor surrounding foot of tub floor, a door panel coming off door into tub room and plaster and paint chipped on the walls.

The Superintendent of Environmental and Maintenance Services confirmed all plastering and painting of repairs done by the maintenance staff in the home should be done in a timely manner by an outside vendor and that it is the home’s expectation that the home is maintained in a good state of repair. [s. 15. (2) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.
Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the "Least Restraint" (NUMBER: r-30) policy is complied with.

The "Least Restraint" (NUMBER: r-30) policy states, "the physician's order shall be noted on the resident's medical record (Physician Order Sheet) and shall include, but is not limited to: type of restraint or PASD to be used." Record review for two identified residents revealed they did not have a physician's order for the use of a PASD.

The "Least Restraint" (NUMBER: r-30) policy states, "Physical restraints and PASDs must be inspected a minimum of every hour by a Registered staff member or by another member of staff authorized by registered staff." Record review revealed personal support workers were not documenting hourly checks for four identified residents.

The "Least Restraint" (NUMBER: r-30) policy states, "In a non-emergent situation and on a quarterly basis, the RN will complete a resident assessment using "Restraint/PASD Assessment". Record review for an identified resident revealed the quarterly Restraint/PASD Assessment was signed, but incomplete where by none of the assessment questions were answered. The Registered Practical Nurse in the home care area and the Acting Administrator confirmed the quarterly assessment was incomplete.

The "Least Restraint" (NUMBER: r-30) policy states, "Consent will be renewed annually at the annual care conference." A clinical record review revealed the following:
- Five identified residents had a Multidisciplinary Care Conference and the PASD consent was signed without any indication of a date where by the PASD was renewed at the annual conference.
- Three identified residents had a Multidisciplinary Care Conference and the PASD consent was not reviewed as initial consent was not obtained. This was confirmed by the Registered Practical Nurse.
[s. 29. (1) (b)]

WN #12: 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 failed to ensure that the required information is posted in a conspicuous and easily accessible manner.

On May 20, 2014, observation during the initial home tour revealed that copies of the inspection reports from the past two years were not posted in a conspicuous manner. Management and reception were unable to locate the Public Reports. The Director shared that the Public Reports were in a black binder by reception in the book case, however it was noted that the book case was covered by a sign. A review of the binder "Resident/Family Information Binder Volume 2" revealed the spine of the binder was absent of any labeling to identify the content of the binder. [s. 79. (3) (k)]

2. The licensee failed to ensure that the required information is posted in the home.

On May 22 and 23, 2014, it was observed that the most recent minutes of the Family Council meetings was not posted. This was confirmed by the Acting Administrator. [s. 79. (3) (o)]

Issued on this 13th day of June, 2014

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