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
Jul 18, 2014	2014_369153_0003	T-099-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

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

TRILLIUM MANOR HOME FOR THE AGED
12 GRACE AVENUE, ORILLIA, ON, L3V-2K2

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

LYNN PARSONS (153), BARBARA PARISOTTO (558), ERIC TANG (529)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, director of resident care (DRC), nurse manager (NM), food services supervisor (FSS), environmental services supervisor (ESS), program and support services supervisor, quality improvement coordinator (QIC), RAI coordinator, registered dietitian (RD), pharmacist, physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), maintenance person, laundry aide, housekeeper, dietary aide (DA).

During the course of the inspection, the inspector(s) reviewed clinical health records, staffing schedules, drug destruction records, Resident and Family Council minutes, staff training records, food temperatures, nurse call reports, preventative maintenance schedules, job routines, home investigation files, home polices related to falls prevention, skin and wound care, medication management system, continence care, abuse, infection control, pain, missing laundry, complaints;
completed observations of medication administration, dining, provision of care, interaction between staff and resident, completed tour of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
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).

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 failed to ensure the written plan of care sets out clear direction to staff and others who provide direct care to the resident.

A review of the plan of care for resident #003 revealed conflicting information related to rest periods.
The mobility section indicates the following information:
- bedridden
- up in chair for short periods
- requires rest period during the day.

The sleep/rest section indicates the following information:
- can remain in bed in the morning during breakfast
- requires rest periods throughout the day.
The resident was observed throughout the inspection to be up in wheelchair for extended periods of time.
Interviews with registered staff and the DRC confirmed the written plan of care did not provide clear direction. [s. 6. (1) (c)]

2. The licensee failed to reassess and revise the plan of care when the resident's care needs changed or care set out in the plan of care is no longer necessary.

a) A review of the plan of care for resident #003 indicated the resident was palliative. Interviews with staff and the DRC confirmed the resident was not palliative at the time of the inspection and the plan of care had not been reassessed and revised when the resident's care needs changed.(153)

b) A review of resident #010's plan of care indicated the following interventions:
- observe ambulation for endurance and steadiness
- allow resident to pace where they can be observed.

A record review and observations revealed the resident uses a wheelchair for mobility and is no longer able to ambulate independently.
Interviews with staff and the DRC confirmed the resident is not ambulatory and the plan of care had not been reassessed and revised when the resident's care needs changed.(153)

c) A review of the care plan for resident #014 identifies the resident requires:
- one or two person, total assistance for toileting; take to bathroom, transfer on/off toilet.

Interviews with two PSWs revealed that resident #014 does not use the toilet.
Interviews with two RPNs confirmed the plan of care does not reflect the resident’s current care needs. (558)

d) In October 2013, resident #008 experienced a fall. A review of resident #008's care plan dated November 13, 2013, failed to include strategies for fall prevention.
Interviews with a RPN, NM, and the DRC confirmed that resident #008's plan of care should have been revised to contain fall prevention interventions. (529) [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 to ensure that:
- the written plan of care sets out clear directions to staff and others who provide direct care to the resident
- the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, 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 any policy and procedure put in place is complied with.

a) The home's policy titled, medication pass #3-6 dated January 2014 states under step 8a:
- to document on the medication administration record in proper space for each medication administered or document by code if the medication is not given.

Resident #008 was prescribed an analgesic to be administered daily at 12:00p.m. and 5:00p.m. for the month of October 2013. A review of the resident's medication administration record(MAR) revealed two missing signatures for the 12:00p.m. dose on October 17 and 29, 2013.
Interviews with a RPN, NM, and DRC confirmed that the home's medication pass

policy and procedure was not followed for resident #008.

b) The home's policy titled, monitoring and documentation of resident response to medication #NPC J-55 dated November 2011 states under step B:
- to document the administration of the medication, the reason for administering the medication and the effectiveness of the medication.

A review of the MAR for resident #009 indicated an analgesic was administered on December 1, 2013, and did not indicate a reason for administration.
Interviews with a RPN, NM, and the DRC confirmed that staff did not comply with the home's policy.

c) The home's policy titled, drug destruction and disposal #5-4 dated January 2014 states under step 13:
- list all surplus and discontinued monitored medications on a separate drug destruction and disposal monitored medication list
- the list shall include documentation of: the date of the removal of the drug from the drug destruction area, prescription number, drug name, strength and quantity, reason for destruction.

A review of the home's drug destruction and disposal narcotic and controlled substances forms provided the following information:

Oro-Medonte
- entry #6 and #9 - missing staff initial
- entry #3, #12 and #13 - missing date

Orillia
- entry #1, #13 and #14 - missing staff initial
- entry #2, #3 and #5 - missing date
- entry #5 - missing prescription number

Severn
- entry #3, #4, #5, #6, #7 and #8 - missing reason for destruction
- entry #7 and #8 - missing staff initial
- entry #6 - missing quantity for destruction
- entry #14 - missing date

Ramara
- entry #7 and #8 - missing date
- entry #4 and #5 - missing staff initials
- entry #5 - missing quantity for destruction.

Interviews with RPNs, NM, and DRC confirmed that the registered staff did not follow the drug destruction and disposal policy and procedure for completing the drug destruction and disposal narcotic and controlled substances forms.

d) The home's policy titled, expiry and dating of medications #5-1 dated January 2014, states under step 2:
- remove any expired medications from stock and order replacement if necessary.

On June 20, 2014, at 8:59a.m. in the Severn home area the inspector observed a bottle of soflax with an expiration date of January 2014, and a bottle of milk of magnesia with an expiration date of February 2013, in the medication cart. Interviews with a RPN, NM, and DRC confirmed that the expired medications should have been removed from the medication cart.

e) The home's policy titled, head injury routine (HIR) #NPC F-40 dated February 2011, states under step A:
The HIR is to be completed as follows:
- every 15 minutes for one hour
- every one hour for four hours
- every four hours for 24 hours.

In October 2013, resident #008 experienced an unwitnessed fall and a head injury routine was initiated. A HIR was completed every 15 minutes until midnight. Paramedics arrived on the night shift and transferred the resident to the hospital. Interviews with the RN and DRC confirmed that the HIR required at 12:15a.m. on the identified date was not documented. [s. 8. (1) (a),s. 8. (1) (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 to ensure that the following home policies are complied with;
- medication pass
- monitoring and documentation of resident response to medication
- drug destruction and disposal
- expiry and dating of medications
- head injury routine, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The following areas /items were noted to require repair:
Ramara:
television lounge across from nurses' station and outside dining room
- stained ceiling tiles

Oro-Medonte:
bathroom between shower and tub room
- call station displaced, hanging off wall

shower room
- ceiling paint chipped and flaking around shower light

tub room
- chipped ceramic wall tile near baseboard

lounge across from nurses' station
- television sitting on the floor

hallway outside resident room #128
- pot light not lit

Orillia:
resident room #025 bathroom
- paint chipped on wall in bathroom

television lounge
- stained ceiling tile
- wall paper hanging off the corner of the wall outside the television sun lounge
- wall damage

outside room #27 & #28
- pot light not lit, no light bulb in the socket

Severn:
sun room
- drywall damage
- ripped fabric on arms of chairs and couch
- scraped armrests on chairs.

A review of the maintenance requisition logs revealed none of the above items were recorded.
The ESS is aware of the areas and recorded the areas of disrepair for follow-up. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home and furnishings are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

a) On June 13, 2014, in Oro-Medonte resident room #109 the inspector was unable to activate the bedside call bell. There was no audible sound or light activated in the hallway outside the resident's room. A RPN entered the room and confirmed the call bell was unable to be activated and stated a report would be submitted to maintenance for repair.

b) On June 13, 2014, in Ramara resident room #208 the inspector was unable to activate the washroom call bell. A RPN arrived and was unable to activate the call bell. The RPN immediately informed the ESS of the situation. The ESS confirmed that the call bell was unable to be activated and stated a work requisition would be completed for repair.

c) On June 13, 2014, at 11:20a.m. in Orillia resident room #007 the inspector was unable to activate the bedside call bell. A PSW was asked to activate the call bell and confirmed the call bell was not working. The PSW informed the RPN who stated a requisition would be sent to maintenance for repair.

During stage 2 the identified call bells were observed to be operational. [s. 17. (1) (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 to ensure the resident-staff communication and response system is on at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen a post-fall assessment was conducted using a clinically appropriate assessment instrument.

A review of the resident assessment instrument – minimum data set (RAI MDS) completed for resident #009 identified a fall. In July 2013, the resident was found on the floor. A record review indicated a post fall assessment using a clinically appropriate instrument was not completed.

An interview with a RPN, QIC, and the DRC confirmed that a post fall assessment using a clinically appropriate instrument was not completed. [s. 49. (2)]

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 a post fall assessment is completed using a clinically appropriate assessment instrument when a resident has fallen, to be implemented voluntarily.

WN #6: 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 a resident exhibiting altered skin integrity, including skin breakdown and pressure ulcers has been assessed by a registered dietitian who is a member of the home.

a) Resident #012 was noted to have a stage 2 pressure area involving an identified area.
A review of the clinical health record failed to reveal a referral to the RD.
An interview with the RD confirmed a referral had not been received for resident #012 for a nutritional assessment related to altered skin integrity.
An interview with the DRC confirmed a referral to the RD should have been completed for resident #012.

b) Resident #008 was reported to have a stage 2 pressure ulcer involving an identified area.
A review of the clinical health record failed to locate a referral to the RD.
When interviewed the RD and the DRC confirmed a referral to the RD should have been completed for a nutritional assessment related to skin breakdown for resident #008. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown and pressure ulcers has been reassessed at least weekly by a member of the registered nursing staff.

a) A review of resident #013's clinical health record revealed the weekly skin assessment template was not completed except for two identified weeks.
Interviews with three registered staff revealed a lack of awareness of the requirement to use the skin assessment template for the weekly assessments.
When interviewed the DRC confirmed the skin assessment template should have been completed weekly.

b) Resident #008 was assessed to have a stage 2 pressure ulcer involving two identified areas. A review of the clinical health record revealed the weekly skin assessment template was not completed except for two identified weeks.
An interview with the DRC confirmed weekly skin assessments were not completed and the skin assessment template was not used for resident #008.

c) A review of resident #012's clinical health record failed to reveal weekly skin assessments for a stage 2 pressure ulcer.
When interviewed registered staff confirmed that skin assessments were not completed and the skin assessment template had not been used.
An interview with the DRC confirmed a weekly skin assessment using the skin assessment template should have been completed for resident #012. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- a resident exhibiting altered skin integrity, including skin breakdown and pressure ulcers has been assessed by a registered dietitian
- a resident exhibiting altered skin integrity, including skin breakdown and pressure ulcers has been reassessed at least weekly by a member of the registered nursing staff, 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 steps are taken to ensure all areas where drugs are stored are kept locked at all times, when not in use.

On June 25, 2014, at 10:35a.m. on the Ramara home area, the medication room door was observed to be propped open and the medication cart was unlocked with no staff in attendance.
The inspector informed the RPN that the medication room door was open and the medication cart unlocked. The RPN indicated she was just around the corner in the nurses' station.
An interview with the DRC confirmed the medication room door should not have been propped open and the medication cart should have been locked. [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 steps are taken to ensure 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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure there is a documented reassessment of each resident's drug regime at least quarterly.

On June 19, 2014, a review of resident #012's most recent reassessment of the drug regime revealed it was completed by the physician on January 30, 2014.
The next reassessment of the resident's drug regime should have been completed April 30, 2014.
Staff were unable to locate any additional drug regime reassessments after January 30, 2014.

Interviews with registered staff and the DRC confirmed a reassessment of resident #012's drug regime had not been completed at least quarterly. [s. 134. (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 there is a documented reassessment of each resident's drug regime at least quarterly, 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. (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. (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 ensure that staff participate in the infection prevention and control program.

a) On June 13, 2014, in the Severn, Orillia, Oro-Medonte and Ramara tub and shower rooms,the inspectors observed unlabeled personal hygiene products including deodorant sticks, unlabeled hairbrushes and combs.
On June 16, 2014, in the Orillia tub and shower room the inspector observed an unlabeled comb, hairbrush and two deodorant sticks.

An interview with the NM confirmed that personal hygiene products such as combs, hairbrushes and deodorant should be labeled and stored in each resident's bathroom. The NM indicated that personal hygiene products should not be stored in the bath and shower rooms. The inspector and NM visited the Oro-Medonte shower room, and observed unlabeled personal hygiene products.

b) On June 19, 2014, at 12:20p.m. on the Orillia home area, it was observed during lunch that a DA was wearing gloves while serving the residents. The DA removed used clothing protectors and placed them into the soiled linen cart, proceeded to serve

entrees to residents, plated bread using a gloved hand and cleared dirty dishes, all without performing hand hygiene or changing the gloves.

An interview with the DA confirmed that hand hygiene was not performed between activities during lunch service. An interview with the FSS confirmed staff should be sanitizing hands. [s. 229. (4)]

2. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission.

In May 2013 resident #022 was screened for tuberculosis, 56 days after being admitted to the home.

An interview with the NM confirmed that resident #022 was not screened for tuberculosis within 14 days of admission. [s. 229. (10) 1.]

3. The licensee failed to ensure residents are offered immunizations against tetanus and diphtheria.

A review of resident #022’s personal health record failed to reveal an offer for immunization against tetanus and diphtheria. Consents obtained on admission included annual influenza, pneumovax and admission 2-step mantoux skin test.

An interview with the NM and the DRC could not confirm that tetanus and diphtheria were offered at admission to resident #022. [s. 229. (10) 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:
- staff participate in the implementation of the infection prevention and control program
- each resident admitted to the home is screened for tuberculosis within 14 days of admission
- each resident is offered immunization against tetanus and diptheria, to be implemented voluntarily.

WN #10: 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 ensure that each resident of the home has his or her personal items, including personal aids cleaned as required.

On June 16-19 and 23, 2014, it was observed that resident #011's wheelchair had white stains on the left side of the back cushion and the right side of the seat cushion in addition to a dried orange food stain on the right side of the wheelchair's frame.

An interview with a PSW revealed that the night shift PSW is responsible for cleaning wheelchairs and walkers. Upon observation of the chair the PSW confirmed the wheelchair was dirty.

A review of the PSW night shift routine states
- Steam clean wheelchairs and walkers for those whose baths are in the morning

An interview with the NM confirmed the ambulation equipment is cleaned weekly the night before a scheduled bath or shower. Upon observation of the wheelchair with the NM the orange food stain had been cleaned by the PSW previously interviewed. The white stains were identified to the NM. [s. 37. (1) (b)]

WN #11: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Interviews with the Residents' Council President and the administrator confirmed advice was not sought in developing and carrying out the satisfaction survey. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On June 20, 2014, at 8:59a.m. on the Severn home area, the inspector observed the following non drug-related supplies on the medication cart:

- unlabeled nail clippers
- bank card
- SIN card
- mailing stamps
- jewelry bracelets
- disinfectant chemical.

Interviews with a RPN, NM, and DRC confirmed the above-mentioned items are not to be stored in the medication cart. [s. 129. (1) (a)]

Issued on this 23rd day of July, 2014

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