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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 11, Apr 4, 2015	2015_251512_0002	T-1760-15	Resident Quality Inspection

Licensee/Titulaire de permis

UNIONVILLE HOME SOCIETY
4300 Highway #7 MARKHAM ON L3R 1L8

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

UNION VILLA
4300 Highway #7 Unionville ON L3R 1L8

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

TILDA HUI (512), MATTHEW CHIU (565), VALERIE PIMENTEL (557)

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, 17, 18, and 19, 2015.

Additional inspections related to the following Log#s were also completed during this inspection:
1) T-1150-14, critical incident,
2) T-1789-15, complaint.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), nurse managers, human resources manager, food service manager (FSM), environmental support service supervisor (ESSS), activation manager, registered dietitian (RD), physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), activation staff, dietary aide (DA), housekeeping aide, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in home and resident's areas, observation in care delivery processes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

17 WN(s)
7 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. (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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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 that there is a written plan of care that sets out the planned care for the resident.

The inspector observed on two identified dates, two half side rails up at the head of resident #004's bed.

Record review revealed that the resident's plan of care does not include the use of half side rails while resident is in bed.

An interview with the resident confirmed the resident uses the side rails to assist him/her with turning, repositioning, sitting up and getting in and out of bed.

Interviews with identified staff members confirmed that the two half side rails were up on the resident's bed. The DOC confirmed that the written plan of care for the resident does not set out the planned care for the resident. [s. 6. (1) (a)]

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

Record review revealed that resident #009 is incontinent for bladder and bowel and uses incontinent briefs at all times.

Interview with an identified registered nursing staff indicated that the resident was incontinent for both bladder and bowel. However, interview with the resident and an identified care giver revealed that the resident is aware of when he/she has the urge to go for both bladder and bowel, and was kept continent during the day by regular toileting. The resident's incontinent briefs would be wet if he/she was not toileted. The conflicting information indicated a lack of collaboration between nursing staff in the continence assessment of the resident. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review revealed that resident #010 uses an identified care product which has specific cleaning instructions as specified in the plan of care.

Interview with an identified PSW indicated that he/she did not use the specific cleaning method as mentioned above to clean the care product for the resident. Interview with the registered nursing staff confirmed that the PSW is not following the procedures to clean the care product as indicated in the resident's care plan. [s. 6. (7)]

4. 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.

Record review revealed that resident #004 was identified as occasionally incontinent of bowel and frequently incontinent of bladder in a quarterly minimum data set (MDS)

assessment on an identified date. The resident was identified as incontinent for both bowel and bladder in MDS assessment conducted on a second identified date three months later, indicating a deterioration of his/her continence status. There was no evidence of a continence assessment conducted on the resident between these two above mentioned periods.

Interview with an identified registered nursing staff and the nurse manager, who is the lead for the continence care program, confirmed that a continence assessment should have been conducted for the resident when the resident's care needs changed. [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 there is a written plan of care that sets out the planned care for the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that the care set out in the plan of care is provided to the resident as specified in the plan, and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation made on an identified date in an identified shared resident's room, noted a signage indicating bed A and bed B are to be placed on opposite sides of the room. However, the inspector observed bed B was placed on the same side of the room as bed A and there was no call bell available for bed B.

Interview with an identified registered staff confirmed that as bed B was moved to the same side of the room as bed A, there was no call bell available for bed B. The registered staff indicated he/she would add a call bell for bed B.

On an identified date, the inspector observed a call bell was added to bed B in the same room. [s. 17. (1) (d)]

2. The licensee has failed to ensure that the resident-staff communication system is available in every area accessible by residents.

Observation made on an identified date and time noted a call bell system was not installed in the enclosed courtyard accessible by residents from the ground floor lobby.

Interview with the environmental support service supervisor (ESSS) and the administrator confirmed that residents do have unsupervised access to the courtyard and a call bell system should have been installed. [s. 17. (1) (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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, and is available in every area accessible by residents, to be implemented voluntarily.

WN #3: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

a. Record review of resident #007 revealed and interviews with identified registered nursing staff and PSWs confirmed that the resident has an identified responsive behaviour. Staff members have been responding to the resident when he/she exhibited the identified responsive behaviour. Record review indicated that the resident's identified responsive behaviour was not included in his/her plan of care.

Interviews with an identified registered nursing staff and two identified nurse managers confirmed that the plan of care was not based on the interdisciplinary assessment of the resident's identified responsive behaviour.

b. A review of resident #007's progress notes on two identified dates, and the MDS assessment dated in the same month, indicated that the resident had an identified responsive behaviour. Record review of the progress notes, the MDS assessment dated three months later, and interviews with identified registered nursing staff and PSWs indicated that the resident has not demonstrated any of the identified responsive behaviour in the last three months.

Review of the resident's plan of care and interviews with the identified nurse managers confirmed that the resident demonstrated an identified responsive behaviour in the first identified period. The plan of care at the time was not revised based on the interdisciplinary assessment of the resident's identified responsive behaviour. [s. 26. (3) 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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: 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 each resident of the home is bathed by the method of his or her choice as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Interview with an identified family member for resident #005 revealed that the resident has been receiving showers twice a week. The family member spoke with a member of the nursing management staff in an identified period of time, that he/she would like the resident to have a tub bath at least once weekly as the resident preferred a tub bath.

Interview with the identified nursing management staff confirmed he/she was aware of the request from the family member. Interviews with an identified PSW and the nursing management staff also confirmed that the resident has been receiving showers twice a week but not the tub baths.

Record review and interviews with the nursing management staff confirmed that there was no assessment and clinical record indicating that the resident has a medical condition contraindicating with him/her having a tub bath. [s. 33. (1)]

2. Record review of the PSW Observation and Monitoring Flowsheet for resident #009 over a six month period revealed in two identified weeks, the resident refused his/her bath and no makeup bath was given. During the following five identified weeks, there was no documentation indicating whether the resident received or did not receive a bath. The written care plan indicated the resident was to receive a shower on a week evening once a week, there was no documentation to support a bath being given once a week and no second bath/shower scheduled.

Interviews with an identified registered nursing staff and the DOC confirmed that the resident should have received two tub baths/showers each week. [s. 33. (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 each resident of the home is bathed at a minimum, twice a week by the method of his or her choice as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, 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 has failed to ensure that the residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented.

Record review revealed that resident #009 exhibited an altered skin integrity on his/her coccyx on an identified date. The resident was not referred to the registered dietitian (RD) for an assessment on or after the identification of the altered skin integrity.

Interviews with an identified registered nursing staff, the RD, and the DOC confirmed that the home's staff only refer residents with open wounds to the RD, and not when additional altered skin integrity is identified. [s. 50. (2) (b) (iii)]

2. Record review revealed that resident #006 who exhibited an altered skin integrity on his/her coccyx on an identified date was not referred to the RD for an assessment on or after the identification of the altered skin integrity.

Interviews with an identified registered nursing staff, the RD, and the DOC confirmed that the resident should have been referred to the RD for an assessment upon identification of the altered skin integrity. [s. 50. (2) (b) (iii)]

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

Record review revealed that resident #009 was identified as having an altered skin integrity on his/her coccyx on an identified date. There were no weekly skin and wound assessments conducted for the resident from the date the altered skin integrity was first identified to 22 days after when the identified altered skin integrity had progressed.

Interview with an identified nurse manager and the DOC confirmed that the weekly skin and wound assessments should have been conducted for the resident during the above mentioned periods. [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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds have been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented, and that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been 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. 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 a medication cart that is used exclusively for drugs and drug-related supplies.

Observation made on an identified date, time, and unit, revealed non-medication items in the narcotic cupboard among the narcotic medications, including one watchmate monitor, one box of AA battery, one wallet, one package of coins, one five-inch paring knife, one wrench, one envelope with a $20 bill, and one key ring with keys. The inspector also observed two packages of AA battery, three pieces of a 9V battery, and a nail clipper in a plastic dish inside the top drawer of the medication cart.

Interview with an identified registered nursing staff and the DOC confirmed that non-medication related items should not be stored in the medication cart or the narcotic cupboard. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #7: 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

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).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive annual training in falls prevention and management.

Review of staff training records revealed and interview with an identified management staff confirmed that 26 per cent of direct care staff did not receive training in falls prevention and management in 2014. [s. 221. (1) 1.]

2. The licensee has failed to ensure that direct care staff were provided with training in skin and wound care.

Record review indicated no evidence of any skin and wound training conducted in 2014 for direct care staff.

Interview with an identified nursing management staff who is the lead of the skin and wound program indicated that the training data for 2014 was tracked by a former management staff who had since left the organization, and there was no other means to retrieve the data. The training report provided by the current management staff did not indicate training for skin and wound was provided to the staff in 2014. [s. 221. (1) 2.]

3. The licensee has failed to ensure that training related to continence care and bowel management were provided to all staff who provide direct care to residents in 2014.

Record review indicated that 26.2% of direct care staff did not receive continence care and bowel management training in 2014.

Interview with the DOC confirmed that not 100% of all direct care staff received the training in 2014. [s. 221. (1) 3.]

4. The licensee has failed to ensure that all staff who provide direct care to residents received annual training in behaviour management.

Review of the staff training records revealed and interview with an identified management staff confirmed that 13 per cent of direct care staff did not receive training in behaviour management in 2014. [s. 221. (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 that direct care staff are provided with annual training in falls prevention and management, skin and wound care, continence and bowel management, and behaviour management, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted.

Interview with an identified registered nursing staff and an identified PSW indicated that the clothing of resident #042 was noted to be wet to a point that warranted changing after receiving a hair wash from the home's hairdressing contract service provider. Interview and observation of the hairdressing contract service provider revealed that although a layer of towel and two layers of apron were used to protect the resident's clothing during hair wash, the plastic apron used to channel water from the hair wash to the drainage sink was torn and in disrepair, resulting in possibility of water leaking back to the resident's clothing from around the collar. The home's solution was to have the home's nursing staff change the resident's clothing after a hair wash if the resident's clothing was wet.

Interview with the administrator confirmed that the home did receive complaint from the family member of the resident's clothing being wet after a hair wash by the hairdressing contract service provider. [s. 3. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system required by the Act or Regulation to be put in place is complied with.

The home’s policy titled Resident Support Services, Policy #RCS K-15, Subject: Dental Services, revised September 9, 2010, indicated that all new admissions are to have a dentist/denturist consultation referral completed and forwarded to the clinic coordinator. The policy further stated that there would be no fee for the initial assessment.

The home's process to arrange for residents to attend the dental clinic is the coordinator will enter the residents' names onto a list and forward the list to the service provider. The service provider will then contact the substitute decision makers (SDM) for confirmation of funds to prepay the dental assessment. Once confirmation has been received the service provider sends a confirmed list of those residents to be seen on the next clinic date to the coordinator.

Review of resident #004’s plan of care revealed that a resident oral assessment agreement form was signed by the SDM on an identified date. This information was given to the clinic coordinator, however the identified dentist/denturist consultation referral form was not completed. The clinic coordinator said he/she had never seen this form and it was not used. Resident #004’s name was not on the list for the dental clinic on an identified date 30 days after the agreement form was signed. Interview with the clinic coordinator confirmed the service provider only enters those residents on the clinic list who has prepaid for their assessment fee.

Interview with the clinic coordinator and the DOC confirmed the homes policy for dental service was not complied with. [s. 8. (1) (b)]

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 has failed to ensure the home is maintained in a good state of repair.

On two identified dates, the inspector observed cracks on the ceiling in the hallway outside four identified resident's rooms. Length of the cracks ranged from three to seven feet.

Interview with the environmental support services supervisor confirmed the above mentioned disrepair. [s. 15. (2) (c)]

WN #11: 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 has failed to 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.

Interviews with an identified nurse manager and an identified registered staff indicated that the home uses a risk management assessment instrument in PointClickCare (PCC) to assess a resident after each fall.

Resident #004 is at risk for falls as per the written plan of care. Record review revealed that the resident fell on an identified date in the hallway, and there was no indication of a post-fall assessment having been conducted.

Interview with an identified nurse manager and registered nursing staff confirmed that the post-fall assessment should be conducted using the risk management assessment instrument for the fall, but it was not carried out. [s. 49. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home has policies titled "Behavioural Management (P.I.E.C.E.S.), policies #16901, #16905 and #16910 developed to meet the needs of residents with responsive behaviours.

Review of the above mentioned polices revealed that these policies were first approved on January 5, 2005, and policy #16901 was last revised in June, 2011.

Interview with an identified nurse manager confirmed that the home has not evaluated annually nor have they updated the written policies and the resident monitoring, reporting and referral protocols developed to meet the needs of residents with responsive behaviours. [s. 53. (3) (b)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council's advice related to concerns or recommendations.

Record review of the Residents’ Council's meeting minutes dated September 4 and October 2, 2014, revealed that the council raised concerns about staffing on resident home areas during the meetings.

Interview with the Residents’ Council president indicated that the council did not receive any response from the home in writing in relation to the above mentioned concerns.

Review of the Residents’ Council's meeting minutes for the above mentioned meetings indicated there was record of written responses from the home to the concerns raised.

Interview with the administrator confirmed that the written responses in the meeting minutes were not given to the council within 10 days of receiving the Residents' Council’s concerns. [s. 57. (2)]

WN #14: 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 failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices; and
(d) use of personal protective equipment.

Record review revealed the percentage of staff received the following training in 2014:
(a) hand hygiene - 77.8%
(b) modes of infection transmission - 76.4%
(c) cleaning and disinfection practices - 76.4%, and,
(d) use of personal protective equipment -76.4%.

Interview with an identified management staff confirmed that an average of 23% of all staff did not receive retraining in infection prevention and control in 2014. [s. 76. (4)]

WN #15: 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 has failed to seek the advice of the Family Council in developing and carrying out the survey.

Interview with the Family Council president revealed that the home conducted a family satisfaction survey in 2014 but the home did not seek the advice of the council in developing and carrying out the 2014 family satisfaction survey.

Record review of the 2014 Family Council meeting minutes indicated that there was no discussion held related to the 2014 satisfaction survey at the meetings.

Interview with the administrator confirmed that there is no evidence indicating the home had sought the advice of the Family Council in developing and carrying out the 2014 satisfaction survey. [s. 85. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of any incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Record review revealed that resident #023 fell on an identified date. The resident was sent to the hospital on the same day and was diagnosed with an identified injury.

Record review of the critical incident report indicated that the above mentioned incident was reported to the Director six days later following the incident.

Interview with an identified nursing management staff confirmed that the home first reported the incident to the Director by submitting a critical incident report to the Ministry of Health and Long-Term Care (MOHLTC) six business days after the occurrence of the incident. [s. 107. (3) 4.]

WN #17: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 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. (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 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.

Record review revealed the infection prevention and control program's last evaluation and annual review was conducted on January 15, 2014, for the year 2013.

Interview with the DOC confirmed there was no evaluation or annual review of the home's infection prevention and control program conducted in 2014. [s. 229. (2) (d)]

2. Record review of resident #004, #031 and #032’s plan of care indicated these residents received two-step mantoux skin tests for tuberculosis screening.

Interview with the DOC confirmed that the home is aware that the mantoux skin test is not best practice and that a chest Xray is best practice for residents over the age of 65 as indicated in the National TB Screening Recommendation. [s. 229. (2) (d)]

3. The licensee has failed to ensure that a written record is kept relating to each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

An interview with the DOC confirmed there was a written record of the annual evaluation of the infection prevention control program for 2013 but the evaluation did not include the dates that changes were implemented. [s. 229. (2) (e)]

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

Observation made on an identified date, time, and floor noted an identified RPN administering oral medication to resident #001 in the dining room at the end of breakfast service. The RPN returned to the medication cart after administering oral medications to the resident, signed on eMar, and proceeded to take medication out for the next administration. No hand hygiene was observed performed by the RPN between the two medication administrations.

Interview with the RPN confirmed that he/she should perform hand hygiene between residents when administering medications. Interview with the DOC confirmed that hand hygiene is required between medication administrations. [s. 229. (4)]

5. Observation made on an identified date, time, and floor noted a care cart inside a spa room with an open container of white petroleum, unlabeled and with hair inside.

Interview with an identified PSW stated the home's staff put labels on white petroleum containers, use one container for each individual resident, and keep the containers in

residents' washrooms. The PSW was not sure why this unlabeled container was on the care cart. Interview with the DOC confirmed that personal care items are to be labeled and used for individual residents only.

Observation made on an identified date, time, room, and floor, noted a contact precaution sign on the door with supplies in a caddy outside the room door. A few gowns were noted inside the caddy but no gloves nor masks. Precaution sign on the door indicated that the PPE required includes gloves, gowns and masks. The inspector spoke to an identified PSW who indicated that masks and gloves were supposed to be in the caddy and he/she would inform registered nursing staff as they were responsible to restock the PPE supplies.

On an identified date and time, an identified housekeeping aide came out of an identified room and went into another room wearing a pair of gloves and holding a bottle of chemical in his/her hands. The inspector followed the housekeeping aide into the room and observed him/her proceeded to spray and clean the counter surface in the resident's washroom. Upon enquiry by the inspector, the housekeeping staff admitted wearing the same pair of gloves in both resident's rooms, and admitted not performing hand hygiene between cleaning the two rooms.

Interview with the environmental support services supervisor confirmed that the housekeeping staff should have removed the gloves after cleaning the first resident's room, and performed hand hygiene before starting to clean another resident's room.

Observation made on an identified date and time noted unlabeled residents' personal care supplies in two identified shared washrooms. Unlabeled items included tooth brushes, hair comb, and dentures in denture cup.

Interview with an identified PSW confirmed that the personal care items were not labeled as they should be, and that he/she will arrange to have them labeled. [s. 229. (4)]

6. The licensee has failed to ensure that the following immunization and screening measures are in place: 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.

Record review for resident #032 revealed the resident was admitted on an identified

date, and was not screened for tuberculosis until 15 days after admission, using a two-step mantoux skin test.

Interviews with an identified registered nursing staff and the DOC confirmed the resident was not tested for tuberculosis within fourteen days of admission. [s. 229. (10) 1.]

7. The licensee has failed to ensure that the following immunization and screening measures are in place: residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Record review revealed residents #004, #031 and #032 were not offered tetanus and diphtheria immunization.

Interview with the DOC confirmed the home does not practice the offering of immunization against tetanus and diphtheria to the residents. [s. 229. (10) 3.]

Issued on this 21st day of July, 2015

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

Original report signed by the inspector.