Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2014	2014_297558_0014	T-68-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

MAIN STREET TERRACE
77 MAIN STREET, TORONTO, ON, M4E-2V6

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

BARBARA PARISOTTO (558), SOFIA DASILVA (567), TIINA TRALMAN (162)

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): September 9,10,11,15,16,17,19, 22, 23, and 24, 2014.

The following intakes were completed during this inspection: T-662-14, T-823-14 and T-1029-14.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), activities manager (AM), environmental services manager (ESM), dietary manager (DM), registered dietitian (RD), staff educator, wound care champion, registered nurses (RN), registered practical nurses (RPN), personal service workers (PSW), dietary aides (DA), housekeepers (HK), residents and family members.

During the course of the inspection, the inspector(s) toured the home, completed dining observations and trialed menu items, observed medication administration, staff to resident interactions and care being provided, reviewed personal health records, recipes, menus, menu nutrient analysis, Residents' Council minutes, Family Council minutes, client services response binder, relevant correspondence and relevant policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled height measurement and weight management LTC-G-60 is complied with.

A review of resident #50's weight record revealed a 14.8% weight loss over a six month period from March 8 to September 8, 2014.

The policy revised in June 2014, states in procedure number six that, a nutrition referral to the RD will be completed and the information documented in the interdisciplinary progress notes for the following weight variances: weight loss or gain of greater than or equal to 10% of total body weight over six months.

An interview with the DM confirmed that a referral for weight change was not received and if a weight warning is identified on the electronic system, a referral should be sent in accordance with the home weight management policy. An interview with the RPN confirmed that a referral should have been forwarded to the RD. The RPN indicated that a referral will be completed and forwarded to the RD. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of resident #15's weight history revealed a 7% weight loss over one month.

The policy revised in June 2014, states in procedure number six that, a nutrition referral to the RD will be completed and the information documented in the interdisciplinary progress notes for the following weight variances: weight loss or gain of greater than or equal to 5% of total body weight over one month.

Interviews with the RN and the DOC confirmed a referral to the RD for resident #15 was not completed. [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 plan, policy, protocol, procedure, strategy or system related to weight management, instituted or otherwise put in place is complied with, 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 is on at all times.

a) On September 10, 2014, in room #211, inspector #558 pulled the washroom call bell cord at which point it detached from the pull station. The call bell system did not activate. The inspector informed an identified PSW who stated a report would be submitted to maintenance for repair. On September 15, 2014, inspector #162 pulled the washroom call bell cord at which point it detached from the pull station. The inspector reviewed the maintenance book which indicated the repair was logged. Documentation indicated the call bell was repaired. The inspector informed an identified RN that the call bell was not functioning. The ED was present at the nursing station and contacted maintenance to repair the call bell. Upon completion of the repair, inspector #162 returned to room #211 and pulled the washroom call bell cord which again detached and did not activate.

An interview with the ED confirmed that a temporary solution was carried out by tying a red plastic cord around the pull station cord. On September 16, 2014, at 11:38 a.m. inspector #162 went to room #211 to re-test the washroom call bell. Upon pulling, the temporary red cord detached and again did not activate. An identified RPN indicated maintenance will be immediately called. On September 24, 2014, at 2:00 p.m. the inspector re-tested room #211 washroom call bell and found the call bell cord at the pull station to be operational.

b) On September 11, 2014, in room #316, inspector #567 was unable to activate resident #01's bedside call bell. On September 15, 2014, in room #316, inspector #162 was unable to activate resident #01's bedside call bell. There was no audible sound or light activated in the hallway outside the resident's room. The inspector spoke with a PSW who confirmed the call bell was unable to be activated and stated a report would be submitted to maintenance for repair.

An interview with the ED revealed that their contracted services for call bells was called and replaced resident #01's bedside call bell. [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 that the home is equipped with a resident-staff communication and response system that is on at all times, to be implemented voluntarily.

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

A review of resident #10's MDS assessments dated November 1, 2013, February 1, April 21, and July 18, 2014 revealed that the resident had stage three pressure ulcers.

A review of resident #10's care plan revealed that changes were not made to reflect nutrition and hydration needs specific to treatment of the pressure ulcers.

An interview with the wound care champion confirmed that the RD was not sent a referral following the discovery of the pressure ulcer or any time thereafter.

Interviews with the wound care champion and the DOC confirmed that the RD should have been sent a referral to assess the nutrition and hydration needs of the resident. [s. 50. (2) (b) (iii)]

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

A review of resident #10's MDS assessments dated November 1, 2013, February 1, April 21, and July 18, 2014 revealed that the resident had stage three pressure ulcers.

An interview with the registered staff confirmed that resident #10 had stage three pressure ulcers dating back to November 2013. An interview with the wound care champion revealed that weekly wound assessments were not conducted the weeks of December 30, 2013, through to June 16, 2014 and July 9, 2014 to September 22, 2014.

An interview with the DOC confirmed that the weekly wound assessments should have been conducted for resident #10. [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, pressure ulcers, skin tears or wounds, 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
- that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle.

A review of resident #50's health record revealed numerous accounts documented between May and September 13, 2014, where the resident refused meals for a variety of reasons, all which resulted in the resident's refusal to eat or noted small intake.

An interview with resident #50 confirmed that he/she cannot eat the foods because many of the menu items are too salty.

An interview with a family member revealed that he/she visits with resident #50 regularly and reported to management that foods served are salty and that he/she has to mix the salty food with another food item to reduce the saltiness. The family member further indicated that the RD or the DM did not review the current menu cycle to identify those foods that the resident finds salty.

An interview with an identified PSW revealed an awareness that resident #50 has complained that the food is too salty to eat. The DM indicated that concerns from the resident and family about foods being too salty was originally identified on May 14, 2014. The DM reviewed the salt content for the previous three days of the menu. Furthermore, the DM indicated that the resident was informed that there is a second menu choice available.

An interview with the DM indicated that the current menu was not reviewed with the resident or family member and that an individualized menu was not developed. The DM agreed that an individualized menu would be appropriate for this resident based on her ongoing complaints related to the menu. [s. 71. (5)]

2. Resident #50 is prescribed a regular diet, regular texture and the resident can receive on request a mechanically altered diet. The plan of care indicates, to provide regular diet, regular texture (try providing one half portion of regular texture and one half portion of minced texture on plate to see if it helps with intake).

A review of the diet information sheet does not identify the half portion intervention as mentioned above. There is no therapeutic extension that reflects the resident's needs for modification of texture and portion. An interview with the DM confirmed the above. [s. 71. (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 an individualized menu is developed for the resident if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response has been made to the person who made the complaint, indicating what the licensee has done to resolve a complaint.

On Saturday, May 10, 2014, an identified family member submitted a complaint

indicating resident #50 sent dinner back complaining it was too salty and that the resident could not eat it.

An interview with the family member revealed that he/she does not recall receiving a response to the complaint made on May 10, 2014. A review of the client services response form, and an interview with the DM, confirmed that a response to the complainant was not carried out. [s. 101. (1) 3.]

2. The licensee has failed to ensure that that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

a) Inspector #558's interview with resident #08 revealed that the resident had complained to the home regarding missing money. A review of resident #08's progress notes revealed that the resident complained to registered staff that a specified amount of money was missing. An interview with the identified registered staff confirmed the complaint was received from the resident, and the complaint was relayed to the ED.

b) Inspector #558's interview with the maintenance worker revealed that resident #09 complained that the first floor shower was out of service for approximately one week in the month of April 2014.

Review of the client services response binder revealed that the home did not have a record of the complaint.

An interview with the ED confirmed that the required documentation pertaining to these complaints were not kept in the home. [s. 101. (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 a response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve a complaint
- The licensee has failed to ensure that that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant, to be implemented voluntarily.

WN #6: 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of residents not to be neglected by the licensee or staff is fully respected and promoted.

On September 22, 2014, at approximately 2:00 p.m. an interview with resident #35, revealed that the resident's catheter bag got twisted and that urine leaked onto the bed and the floor. The resident's assigned PSW was attending an in-service and was off the home area from 10:00-2:00 p.m. A second PSW was covering these hours. When the inspector entered the room just before 2:00 p.m., a PSW was exiting from the resident's bedside with soiled items. The inspector observed the floor by the resident's bedside felt sticky underfoot, and the bed linens covering the resident were wet and visibly stained with urine. An interview with the resident revealed the PSW said he/she was leaving for the day, and that the sheets would be changed by the in-coming PSW.
A review of the care plan indicated that PSWs are required to report any issues with the catheter to the registered staff.
Interviews with the resident's assigned PSW, who had returned from the in-service, and the registered staff, revealed that they were not aware of the incident. The registered staff indicated that care would be provided to the resident immediately. [s. 3. (1) 3.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Review of resident #16's care plan indicated that the resident requires support for toileting as evidenced by inability to complete task safely and independently due to impaired cognition, decreased strength/balance, involuntary movements/motor agitation, high risk for falls and that the resident requires extensive assistance on/off the toilet.

Interviews with PSWs and registered staff revealed that resident #16 is incontinent of bladder and continent of bowel and that the resident is able to toilet self independently. In addition, interviews confirmed that resident #16 uses incontinence pads and/or liners for bladder incontinence. [s. 6. (1) (c)]

2. Review of resident #17's care plan indicated the resident requires support for toileting as evidenced by inability to complete task safely and independently due to responsive behaviour resistive/aggressive with care, severely impaired cognition and

that staff should provide supervision/reminders with toileting tasks.

Interviews with PSWs and registered staff revealed that resident #17 is incontinent of bladder, mostly at night, and continent of bowel and that overall the resident is independent with respect to toileting. Interviews with registered staff and PSWs confirmed that resident #17 does not use incontinence products. Further, staff interviews revealed that the resident is very private and conservative with respect to continence and toileting.

The written plan of care does not provide clear direction to staff regarding continence care and toileting for residents #16 and #17. [s. 6. (1) (c)]

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

On September 16, 2014, during the lunch meal, resident #04 was served regular milk with the entree. According to the written care plan, and diet sheet, the resident is to receive 250ml high protein milk at breakfast, lunch, and dinner.

An interview with an identified dietary aide indicated that the resident receives regular milk at meals. An interview with an identified RPN revealed that it is believed the resident receives high protein milk between meals. The RPN had inquired with the PSW serving beverages, who indicated that regular milk was served in error and that he/she will offer the resident high protein milk. [s. 6. (7)]

4. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #08's care plan completed July 3, 2014, indicates the following as it relates to vision function: wash eye lashes daily with diluted baby shampoo. The physician's order dated January 31, 2014, states, gently rub the base of the eyelids with diluted baby shampoo three times per week in the evening.

An interview with a registered staff member confirmed the care plan was not revised to reflect the change in treatment as per the physician's order dated January 31, 2014. [s. 6. (10) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an allegation of abuse investigation were reported to the Director.

A mandatory report related to an allegation of abuse was submitted to the Ministry of Health on June 20, 2014. The home completed an investigation and reported the incident to the police. The outcome of the home's and police's investigations did not identify abuse.

The DOC confirmed that an amended report detailing the results of the investigation was not reported to the Director. [s. 23. (2)]

WN #9: 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 ensure that the licensee responds in writing within 10 days of receiving a concern from the Residents' Council.

An interview with a Residents' Council member identified a concern regarding oxygen tanks in the home. An interview with the Residents' Council assistant confirmed this concern was raised at the October 24, 2013, meeting and was brought forward to the DOC and ED through email.

Record reviews and interviews with the former DOC confirmed a written response was not provided to the Residents' Council and the current DOC confirmed the present process does not include providing a written response to the Residents' Council. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee, Administrator and staff attend Family Council meetings only when invited.

An interview with the Family Council president and assistant revealed that the resident service coordinator attends all Family Council meetings but is not formally invited. The Family Council president and assistant were not aware of this requirement. [s. 64.]

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 has failed to ensure that the advice of the Residents' Council is sought in developing and carrying out the survey.

Interviews with a Residents' Council member and the AM confirmed that the Council was not involved in the developing and carrying out the satisfaction survey. The survey is developed off site by a third-party and reviewed by a task force assembled by corporate office. [s. 85. (3)]

2. The licensee has failed to ensure that the licensee seek the advice of the Family Council in developing and carrying out the survey.

An interview with the Family Council president and assistant revealed that the licensee did not seek the advice of the Family Council in developing the satisfaction survey for 2014. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On September 10, 2014, the inspector noted a lingering urine odour in the shared washroom for bedrooms #104 and #105. On September 15, 2014, at 12:02 p.m. and at 2:37 p.m., the inspector noted the lingering urine odour to persist.

An interview with an identified housekeeping staff revealed that products A-125 (disinfectant) and 597 (germicidal) are used to clean areas with lingering odours for this shared washroom.
An interview with the ESM revealed that staff are instructed to clean and disinfect those areas with lingering odours at the beginning of the morning shift and to return to follow-up and clean and disinfect as necessary throughout their shift.

On September 16, 2014, at 12:16 p.m. the lingering odour was confirmed by the ESM and that the current implemented plan to manage the lingering odours is not effective and that the urine may have permeated the floor and wall areas around the toilet.

An interview with the ED confirmed that the flooring may need to be replaced to address the lingering urine odour. [s. 87. (2) (d)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

An interview with the DOC indicated that a discussion with the infection prevention and control committee in March 2014, was held regarding offering tetanus and diptheria vaccinations. The DOC confirmed that new admissions have been offered tetanus and diphtheria as of August 2014. Furthermore, the DOC confirmed that residents have not been offered immunization against tetanus and diphtheria in 2012 and 2013. [s. 229. (10) 3.]

Issued on this 17th day of November, 2014

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

B Ramsoth