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
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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
Aug 17, 18, 2015	2015_382596_0005	T-1770-15	Resident Quality Inspection

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

THERESA BERDOE-YOUNG (596), JANET GROUX (606), NITAL SHETH (500)

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): April 27, 28, 29, 30, 2015 and May 1, 4, 5, 6, 7, 8, 11, 12, 2015.

During the course of the inspection the following critical incident, complaint and follow up inspections were completed: T-904-14, T-670-14, T-1315-14, T-1432-14, and T-612-13.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting director of care (A)DOC, dietary manager (DM), quality clerk (QC), support services manager (SSM), social worker (SW), long term care consultant (LTCC), registered dietitian (RD), resident assessment instrument (RAI) coordinator, receptionist, registered nurse (RN), registered practical nurse (RPN), personal support workers (PSW), housekeeping aide, wound care coach, infection prevention and control (IPAC) lead, residents' council president, family council presidents, residents, friends, and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_163109_0010	596
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2014_219211_0019	596
O.Reg 79/10 s. 50. (2)	CO #001	2014_219211_0019	596

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. 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right not to be neglected by the licensee or staff.
The applicable definition of neglect in O. Reg. 79/10, s. 5. is:
The failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopordizes the health, safety or well-being of one or more residents.

Record review of an identified resident's plan of care indicated the resident should be toileted after breakfast (between 9:00- 10:00 a.m.) and after lunch (between 1:00 and 2:00 p.m.), and that he/she wears disposable briefs during the day and night.

On an identified date in May 2015, at 1:15 pm the inspector observed the identified

resident sitting in a wheelchair near the nursing station on the first floor. At 1:25 p.m., observation of the identified resident's incontinent product being changed in the room by two identified personal support workers (PSW) revealed the resident's brief to be heavily saturated with urine, and the resident's buttocks were reddened. The above mentioned PSW's proceeded to toilet the resident.

During interview, the two identified PSWs confirmed that the identified resident's brief was saturated with urine, and that the resident should have been toileted and changed earlier. Interview with one of the identified PSWs revealed that the resident had been toileted and changed between 7 a.m. and 8 a.m. instead of between 9:00 a.m. and 10:00 a.m., and not again until approximately six hours later when observed by the inspector at 1:25 p.m. The identified PSW reported that he/she had a very busy morning giving care to other residents, and they were working with one PSW short.

Interview with the Acting director of care(A)DOC and Executive Director (ED)revealed that the identified resident should not have been left in an incontinent product saturated with urine for approximately six hours on an identified date in May 2015, and should have been changed according to the toileting schedule directions in the resident's plan of care. [s. 3. (1) 3.]

2. The licensee has failed to ensure that every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

Record review of resident #9's plan of care states that he/she is at potential for complications and discomfort due to constipation with the goal of resident having soft, formed stools every one to three days without straining. Interventions include administering laxatives after three days with no bowel movement to promote defecation, offering fleet enema and re-approach resident at another time if he/she refuses. Record review of resident #9's progress notes revealed that the resident was not checked for impaction on an identified date in June 2014. The resident who is deemed cognitively aware, reported to the home that he/she was given an enema by two identified staff members after she had refused it.

Interview with resident #9 revealed that the two identified staff members came into his/her room on an identified date in June 2014 to administer an enema, the resident put up his/her hand and told the staff that he/she did not want the enema. The above mentioned staff members did not explain why the enema was required. Resident #9

reported that she was very upset that the enema was administered without his/her consent, and reported the incident to the management of the home.

Interviews with the two identified staff members revealed that they both entered the resident's room to give him/her an enema, and the resident did not refuse the treatment until after it was administered. Documentation on resident #9's Medication Administration Record (MAR) indicated that the enema was effective.

Interview with the ED revealed that the incident was investigated and the results were inconclusive due to the conflicting information provided by the resident. The two identified staff members were then provided redirection on obtaining consent from the resident prior to administering any medication. [s. 3. (1) 11. ii.]

3. The licensee has failed to ensure that residents’ right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act of residents is fully respected and promoted.

On May 7, 2015, at 11:15 a.m., the inspector observed that a diet sheet was left on the servery counter in the dining room, with no staff around. There were visitors, residents, and private caregivers in the dining room and hallways. The inspector did not see anyone looking and reading the diet sheet, however the information on the diet sheet was easily accessible to anyone in the dining room.

A review of the diet sheet indicated that it listed residents’ diet, texture, allergy, portion size, preferences and special requirements.

Interview with the DM and RD confirmed that the above mentioned information is considered residents’ personal health information and was not kept confidential. [s. 3. (1) 11. 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 every resident's right not to be neglected by the licensee or staff is fully respected and promoted, that every resident's right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent is fully respected and promoted, and that residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act of residents is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

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

Record review of two identified resident's plan of care provides contact precaution interventions to manage a specified condition.

Record review of one identified resident's plan of care indicated to keep resident in his/her room on isolation, wear appropriate (PPE) gowns, gloves, mask, but does not indicate providing and monitoring hand hygiene practices for residents and staff members.

Review of the other identified resident's plan of care revealed that the resident must

remain in his/her room on isolation for the duration of a specified treatment, and does not indicate any other interventions related to contact precautions such as the use of PPE's and hand hygiene.

Interview with several identified nursing staff revealed that hand hygiene before and after resident care are performed, hand hygiene is provided to residents after their meals or when they are in contact with others, and the environment and as needed. [s. 6. (1) (c)]

2. 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 of an identified resident's plan of care revealed that the resident should be toileted after breakfast and after lunch on the day shift. The plan of care indicated that due to aggressive behaviours the resident is not toileted before breakfast, but is washed and a clean brief is applied.

Interview with an identified PSW revealed that he/she did not follow the directions in the resident's plan of care on May 7, 2015. The identified resident was toileted before breakfast between 7:00 a.m. and 8:00 a.m.,and was not aggressive. The above mentioned PSW reported that he/she had not reviewed the resident's plan of care. The care set out in the resident's plan of care was not provided as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that on every shift, (a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review revealed that an identified resident had been been having ongoing skin issues and was assessed by the dermatologist on an identified date in November 2014. The dermatologist ordered a diagnostic test.

Interview with the (A)DOC revealed that the diagnostic test for the identified resident was contaminated, and due to miscommunication between the home and the lab, it was not processed. A subsequent diagnostic test was not completed. The (A)DOC confirmed that the dermatologist's order for a diagnostic test for the identified resident was not carried out by the home. [s. 6. (7)]

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

care and the outcomes of the care set out in the plan are documented.

Record review of residents #12's plan of care indicated that staff should provide morning and evening oral care daily to the resident.

A review of PSW documentation in the daily care flow sheets for resident #12, revealed that identified staff did not document the resident receiving oral care on the day shifts on one identified date in February, four identified dates in March and four identified dates in April 2015.
Also on the evening shifts on one identified date in February, two identified dates in March and three identified dates in April 2015.

A review of PSW documentation in the daily care flow sheets for resident #21, revealed that staff did not document the resident receiving oral care during the day shift on an identified date in March 2015, and on the evening shifts on an identified date in March, and two identified dates in April 2015.

Interview with resident #12 indicated that he/she received assistance with oral hygiene sometimes, and did not always receive oral care assistance in the morning and at night.
Interview with an identified PSW indicated that he/she did not know about the documentation, but always brushed the resident's teeth and provided oral care.

A review of the home's policy entitled Mouth Care #RESI-05-07-14 reviewed December 2002, indicates that the key action is to document the mouth care on the daily care record.

Interview with the (A)DOC confirmed that the staff sometimes forgot to sign the daily care records, and staff should be signing for the oral care provided to the resident. [s. 6. (9)]

5. The licensee has failed to ensure that the outcomes of the care set out in the plan of care are documented.

Record review of an identified resident's plan of care stated that the resident is at high nutritional risk. RD's order indicated specific nutritional interventions.
Record review of the identified resident's plan of care revealed that the resident continues to be fed by mouth and on a specific diet texture and portions.
Record review of the identified resident's Daily Food and Fluid Intake Records between March, April, and May 2015, revealed that there was a total of 105 missing

documentations for either breakfast, dinner, a.m., p.m., and h.s. nourishment. The resident's Enteral Feed Intake Sheets revealed January, February, and May 2015 sheets had a total of 163 missing documentation between the day and evening shifts.

Interview with an identified PSW revealed that the identified resident refuses his/her meals at breakfast, lunch and supper by spitting the food out or refusing to open his/her mouth to eat, and is the reason why the flow sheets only has the g-feed intakes recorded.

Interview with an identified RN revealed that staff did not document the identified resident's food and fluid, and enteral feed intakes on the above mentioned dates but should have. [s. 6. (9) 2.]

6. The licensee has failed to 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, the resident’s care needs change or care set out in the plan is no longer necessary.

Record review of an identified resident's plan of care indicated that the resident is frequently incontinent for bladder and occasionally incontinent for bowel, and wears pull ups during the days and night provided by his/her family. This change was made in the plan of care after the inspector notified the home.

Interview with the resident’s family member confirmed that the resident was changed from one type of incontinence product to another type, because he/she required more assistance with continence care.

Interview with an identified RN confirmed that the resident's incontinent product was changed, and the plan of care was not updated.

Interview with the (A)DOC and two identified staff confirmed that the resident's plan of care was not revised since the resident’s incontinent product was 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 clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, that the provision of the care set out in the plan of care and the outcomes of the care set out in the plan are documented, and that the resident is reassessed and the plan of care 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, 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent

infection, as required.

Record review of an identified resident's clinical record revealed physician's orders for dressing of an alteration in skin integrity. The order indicated that the resident's dressing was to be changed daily in March 2015, and every two days in April 2015. Review of the identified resident's March 2015 Treatment Administration Record (TAR) revealed no sign offs/documentation by registered staff on four identified dates in March 2015. Further review of the April 2015 TAR revealed registered staff sign offs on six identified dates in April 2015. The treatment was not given to the identified resident every two days, as ordered.

Interview with an identified RPN revealed that he/she wasn't sure if he/she administered the treatment to the identified resident as ordered on an identified date in March 2015. Interview with an identified registered nurse (RN)confirmed that the resident's treatment interventions were not done on the above mentioned days in April 2015, as indicated on the TAR. [s. 50. (2) (b) (ii)]

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

Record review of an identified resident's minimum data set (MDS) assessment indicated that the resident had an alteration in skin integrity. Review of the identified resident's clinical record from February 1 to April 30, 2015, revealed that weekly skin assessments were not completed on twice in February and once in April 2015.

Interviews with an identified PSW and identified registered practical nurse (RPN) revealed that the resident's alteration in skin integrity had been chronic, with periods of improvement and deterioration since the resident's admission two years ago. Interviews with two identified RPNs confirmed that the skin assessments were missed on the above mentioned dates. [s. 50. (2) (b) (iv)]

3. Record review of an identified resident's MDS assessment dated March 22, 2015, and interviews with an identified RN, an identified PSW and the resident's family members, revealed that the resident had an alteration in skin integrity, which started in January 2015. Record review of the identified resident's plan of care and interview with an identified RN revealed that weekly skin assessments were completed on March 25, 2015, and not again until fourteen days later on April 8, 2015; the April 1, 2015 weekly

skin assessment was not done, and should have been. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, and that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Observation conducted on April 27, 2015, at 12:00 p.m., revealed that an identified volunteer was found assisting an identified resident with eating while standing.

A review of the home's policy entitled Activity Daily #RESI-05-02-09, version November 2013, indicated that care staff are required to ensure assistance is given to resident as per care plan, including safe positioning and eating techniques.

Interview with an identified RPN confirmed that the volunteer was required to follow safe feeding techniques and should be seated while providing feeding assistance to the identified resident.

Interview with the DM confirmed that the identified volunteer should be seated at the eye level of the identified resident for safe feeding techniques. [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall 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; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has 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 practices.

Record review of the hand hygiene effectiveness audits completed in the months of May was 42%, July 59%, and November 70%.

The home's Hand Hygiene Program Policy # INFE-02-01-06 version January 2013 revealed overall compliance with hand hygiene practices will be calculated, trended and analyzed both by department and on a total home basis.
Where compliance in the home is below a rate of 95%, the IPAC Committee will develop an action plan including care staff re-education to address areas of non-compliance, monthly hand hygiene observations will be completed until there are three consecutive months where compliance is at or above 95%.

Interview with the Quality Assurance Lead verified that an action plan was not developed to address the non-compliance in the months as mentioned above and confirmed that staff were not re-educated. [s. 219. (4)]

2. The licensee has 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 cleaning and disinfection practices.

Record review of the home's training records for cleaning and disinfecting practices which includes hand hygiene, cleaning and disinfecting of equipments and spas revealed that 85 per cent of staff were not trained in 2014. Interview with the quality clerk (QC) revealed that 85 per cent of staff were not trained in 2014. [s. 219. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 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 hand hygiene, and cleaning and disinfection practices, to be implemented voluntarily.

WN #6: 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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the continence care and bowel management training is provided to all staff who provide direct care to residents.

A review of the home's education records for continence care and bowel management training revealed that eighty per cent of staff who provide direct care to residents were not trained in continence and bowel management in 2014.

Interview with the home's QC confirmed that the home did not provide continence care training to all direct care staff and 80 per cent of staff were not provided training on continence care and bowel management in 2014. [s. 221. (1) 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 training in continence care and bowel management shall be provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #7: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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

Findings/Faits saillants :

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

Record review of the Home's Infection Prevention and Control program evaluation for

2014 was not available.

Interview with the QC confirmed that the home did not complete an evaluation of their Infection Prevention and Control program and therefore could not provide any information. [s. 229. (2) (d)]

2. The licensee has failed to ensure that a staff member is designated to co-ordinate the infection prevention and control program who has education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

Record review of the Best Practices for Infection Prevention and Control Programs in Ontario, in all health care settings, 3rd edition, Provincial Infectious Diseases Advisory Committee PIDAC) document revised May 2012 recommends that certain qualifications be met by professionals in IPAC204. It recommends that Infection Control Practitioners (ICPs) must be certified in Infection Control from the Certification Board of Infection Control and Epidemiology (CBIC), and that ICPs must pass a Community and Hospital Infection Control Association (CHICA)-Canada endorsed education program which comprises a minimum of 80 hours of instruction.

Record review of the Infection Prevention and Control Program (IPAC) lead's credentials revealed that he/she did not have education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

Interview with the IPAC lead revealed that he/she had been the lead for about eight months and does not have the required Infection Prevention and Control certification and experience.
Interview with the (A)DOC confirmed that the IPAC lead does not have the certification and experience as mentioned above. [s. 229. (3)]

3. The licensee has failed to ensure that all staff participates in the implementation of the infection prevention and control program.

Observation conducted on April 27, 2015, at 12:00 p.m., in a first floor dining room revealed that staff do not participate in the implementation of the infection prevention and control program. On a few occasions the inspector observed that an identified RPN did

not perform hand hygiene after clearing soiled soup bowls, soiled dishes and cutlery from the table, and before serving main course and dessert to residents. An identified RPN was observed holding a dirty stack of soup bowls and left them on the servery counter while communicating with a dietary aide. The same identified RPN was observed holding soiled dessert bowls in his/her other hand while pushing a cart with desserts to serve residents in the dining room.

Interview with the identified RPN confirmed that he/she should be performing hand hygiene each time after clearing soiled dishes, bowls and cutlery. He/she also confirmed that he/she should not be holding soiled dessert bowls while pushing a cart to serve desserts to residents.

Interview with the DM confirmed that the staff should be performing hand hygiene after clearing soiled bowls and dishes and before serving food to residents. Staff putting a stack of soiled soup bowls on the servery counter, holding soiled bowls while pushing a dessert cart with desserts to serve residents at the same time is not a safe infection prevention and control practice. [s. 229. (4)]

4. During the initial tour on April 27, 2015, the inspector observed a cart containing personal protective equipments such as gloves, gowns, masks, and hand sanitizer outside an identified resident's room door. There was no contact precautions signage on the resident door as required.

Interview with an identified RN and the (A)DOC revealed that the identified resident was readmitted to the home the day before and awaiting swab results. The identified registered staff confirmed that there should have been a contact precaution sign posted on the resident's door. [s. 229. (4)]

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 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, that a staff member is designated to co-ordinate the infection prevention and control program who has education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management, and that all staff participates in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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 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 is complied with.

Record review of the home's policy and procedure entitled Expiry and Dating of Medications 5-1 states that designated medications i.e. eye drops, insulin, must be dated when opened.

On May 1, 2015, inspector's observation revealed eye drops belonging to three identified residents did not have a label that indicated when the medications was opened.

Interview with an identified RPN revealed that the home's policy directs staff to label all eye drop containers with the date it is opened.
An interview with the (A)DOC confirmed that the identified registered staff did not follow policy. [s. 8. (1) (b)]

2. Record review of the electronic treatment administration records (e-TAR) revealed missed documentation for four identified residents om identified dates in March, April and May 2015.

Record review of the home's policy entitled Medication Pass 11-03 dated September 2010 states that once the medications are administered the Registered Staff is accountable and responsible for completing the MAR/e-MAR by initialing for all medications administered or inserting the appropriate code for medications not administered.

An interview with the (A)DOC confirmed that the identified registered staff did not follow the home's policy. [s. 8. (1) (b)]

3. Record review of the home's vaccine fridge temperature monitoring record revealed a total of 49 missing temperature readings in February, March and April 2015.

Interview with an identified RPN revealed that registered staff working on the unit during the days and evenings shift must monitor and document the vaccine fridge temperature in the vaccine fridge temperature monitoring record.

Interview with the (A)DOC confirmed that staff should have monitored and documented the vaccine fridge temperatures in the vaccine fridge temperature monitoring record and that the staff did not follow the home's policy. [s. 8. (1) (b)]

4. Interview with the (A)DOC and the home's long term care consultant revealed that one of the strategies that is followed in response to a contagious condition affecting five identified residents, three identified staff members and one family member that began in April 2015, was to cohort staff to the affected units.

Record review and observations of two identified staff members revealed that both were assigned and worked on the affected units between May 1 to May 7, 2015.

Interviews with the two identified staff members verified that they had been assigned and worked on the affected units as well as the non affected units during the above mentioned time frames in May 2015.

Interview with the Quality Assurance Lead confirmed that the staff mentioned above worked on the affected units during the above mentioned time frames in May 2015 according to the home's staff schedule and did not follow the above strategy. [s. 8. (1) (b)]

5. Record review of the Home's Policy 05-09 dated May 2010 revealed all residents with the specified condition will be treated promptly and contact the physician immediately for the treatment orders for infected residents.

Record review for five identified residents' revealed medical consultations on April 25, 2105 from the dermatologists suggesting a possible contagious medical condition.

Record review of the above residents clinical records and interview with the (A)DOC revealed that treatment for the affected residents was not initiated until the evening of April 29, 2015. [s. 8. (1) (b)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

Record review of an identified resident's progress notes revealed that on an identified date in November 2012, a co-resident of an identified resident reported that an identified staff was rough with the identified resident; this was also confirmed by the identified resident himself/herself. The incident was reported to the DOC and ED.

Interview with the ED revealed that the home was unable to find any records of the investigation and therefore cannot confirm that the Critical Incident report and home's investigation was completed. [s. 23. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Record review of an identified resident's progress notes revealed that on an identified date in November 2012, a co-resident of an identified resident reported that an identified staff was rough with the identified resident; this was also confirmed by the identified resident himself/herself. The incident was reported to the DOC and ED.

Interview with the ED confirmed that the above incident was not reported to the Director. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The continence care 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 of the home's continence care and bowel management program revealed that the home did not complete an annual evaluation of the continence care and bowel management in 2014.

Interview with the home's QC confirmed that the home did not evaluate the continence care and bowel management program in 2014. [s. 30. (1) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program, at a minimum, provide for annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

Record review of the home's continence care and bowel management program revealed that there was no annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff in 2014.

Interview with the home's QC confirmed that the home did not conduct an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff in 2014. [s. 51. (1) 5.]

2. The licensee has failed to ensure that residents are provided with a range of continence care products that are based on their individual assessed needs.

A review of an identified resident's plan of care revealed the resident was using pull-ups then currently changed to a brief; there was no assessment completed when the identified resident was provided pull-ups and briefs on different occasions.

Interview with the Power of Attorney (POA) of the identified resident confirmed that the resident was wearing pull-ups for the past four years, then changed to a brief three months ago when the resident had the flu and required more assistance with continence care.

Interview with the identified registered staff confirmed that there was no assessment completed for the continence care products (pull-ups and briefs) provided to the resident, and interviews with the lead of the continence care program, RAI Coordinator, (A)DOC, and ED confirmed that the resident should have been assessed for the appropriate continence care products. [s. 51. (2) (h) (i)]

WN #13: 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. (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 has failed to ensure 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.

Record review of a Critical Incident (CI) Report #2848-000036-13 indicated that an identified resident communicates by making grunting noises. An identified PSW was found imitating and making the grunting noises back to the resident during supper time on an identifed date in October 2013. Identified visitors found it to be verbally inappropriate behaviour and reported it to the ADOC who is no longer working in the home.
A review of the identified resident's plan of care revealed that there was no documentation available about the investigation mentioned above.

Interview with an identified PSW reported that she was playing with the resident by imitating and making the grunting noise back to the resident, and stopped doing it to the resident after the home directed her not to do it.
Interview with the ED confirmed that the ADOC who completed the investigation of this incident is no longer working in the home, and the home is not able to find the investigation documentation records. The ED confirmed that the home failed to keep the documentation records of the investigation in the home. [s. 101. (2)]

WN #14: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Record review revealed that an identified resident sustained a fall on an identified date in October 2013. The resident was assessed by the nursing and medical staff and was monitored every shift for three consecutive days in October 2013. On October 20, 2013, the physician assessed the resident and an order was made to transfer the resident to hospital, related to swelling. The identified resident returned from the hospital two days later with diagnosis of fracture.

Record review revealed documentation from the DOC in the identified resident's progress notes that he/she was informed via email by the charge nurse on the day shift and the physician, that the resident had a fall on October 18, 2013, and was transferred to hospital with a diagnosis of fracture. The DOC stated in the progress note that "writer is sending in a CIS (critical incident system) to the MOH (Ministry of Health)."

Interview with RN #106 revealed that he/she notified the DOC about resident #8's condition via email on n identified date in October 2013, but the CIS was not submitted to the director and the home's internal incident report was not completed. [s. 107. (3.1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On May 1, 2015, the inspector observed three unlabeled medication cups in the top drawer of a medication cart on third floor. The medication cups contained 8:00 a.m. medications for three identified residents:

Interview with an identified RPN revealed that the three identified residents refused their medications that morning and that he/she was going to re-approach again later on, as these residents would often refuse their medications in the mornings and eventually take them.
During interview with the identified RPN about the home's procedure when a resident refuses a medication, the RPN revealed that staff are expected to document the refusal in the electronic administration record (E-MAR) and the medication should be discarded.

An interview with the (A)DOC confirmed that when medications are refused by residents' registered staff should document the refusal in the EMAR and the medications should be discarded. [s. 126.]

WN #16: 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 May 1, 2015, the inspector observed in the narcotic bin of the medication cart on an identified floor, the following items: a wallet containing identification and credit cards, a health card, money, a watch with a black and white band, a silver wedding band, a silver ring with a silver stone, a silver allergy bracelet in a plastic bag and a pager.

Interview with the (A)DOC revealed that the above mentioned items should not be stored in the medication cart. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided: Cleaning and sanitizing of equipment relevant to the staff member's responsibilities.

Record review of the home's training records revealed that eight identified PSWs hired between 2014 and 2015 did not complete training regarding cleaning and sanitizing of equipment relevant to their responsibilities.

Interview with the QC confirmed that the eight identified newly hired PSWs mentioned above were not trained in cleaning and sanitizing of equipment and spas during orientation. [s. 218. 3.]

Issued on this 22nd day of September, 2015

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

Original report signed by the inspector.