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
Feb 27, 2015	2015_291552_0006	O-001547-15	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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

MARIA FRANCIS-ALLEN (552), GWEN COLES (555), MEGAN MACPHAIL (551), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 9, 10, 11, 12, 13, 17,18, 19 & 20, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Service Coordinator, Environmental Service Manager (ESM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physiotherapy Assistant (PTA), Residents and family members.
The Inspector(s) also toured the home, observed meal service, observed staff:resident interaction, reviewed the licensee policies, reviewed the Family Council and Resident Council minutes and the residents clinical health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
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

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

8 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 the written plan of care for each resident sets out the planned care for the resident.

During an interview Staff #117 indicated that Resident #44 uses two bed rails in upright position and the bed rails assessment is included in the plan of care.

On February 18 and 19, 2015 inspector observed Resident #44 in bed with two quarter bed rails in upright position.

Review of the current plan of care for Resident #44 did not include any focus or interventions related to the use of bed rails.

Staff #117 confirmed that bed rails use is not included in the plan of care for Resident #44. The resident requested the rails to be kept in up position.

The written plan of care for Resident #44 did not include the planned care related to the use of bed rails. [s. 6. (1) (a)]

2. Review of MDS assessment completed on an identified date found that Resident #41 was demonstrating responsive behaviours. Review of the Initial MDS assessment completed on an identified date found no evidence of behaviours.

Interview conducted on February 13, 2015 with Staff #101 who reported that Resident #41 exhibited responsive behaviours. Staff #101 reports interventions include re-direct; leave alone and attempt again later; and have spouse assist when visiting. Interview conducted on February 13, 2015 with Staff #105 who reported that Resident #41 does exhibit responsive behaviours. Staff #105 reports there has been no change in Resident #41’s behaviour since admission but behaviours vary day to day. Staff #105 reports interventions being used for Resident #41 including leave alone and re-approach later; distract; talk about family; and work with spouse when visiting.

Review of MDS assessment, found a Behavioural RAP triggered which indicated “has displayed responsive behaviors. Staff will reassure. No referral required and will care plan with the goal of avoiding complications. Will the behavioural symptoms be addressed in the care plan – Yes”.

Review of Resident #41 plan of care found no evidence related to behaviours and interventions.

Interview conducted with the Director of Care (DOC) on February 13, 2015 who reported all care areas including behaviours would be identified and included in the care plan with related interventions. The DOC reports if a behaviour has been identified and RAP triggered then the behaviour should be indicated on the care plan. The DOC reported that review of Resident #41's plan of care found no evidence of behaviours identified and related interventions. [s. 6. (1) (a)]

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

Review of MDS assessment completed on an identified date found that Resident #41 had a change in toileting function requiring extensive assistance with 1 person assist; was incontinent of bowel; frequently incontinent of bladder; and wears an incontinence product.

Interview conducted on February 13, 2015 with Staff #101 who reported that Resident

#41 was incontinent of urine and wears a incontinence product 24/7, however is not incontinent of bowel as the resident is able periodically to indicate when he/she needs to use the washroom, and is able to toilet self with some supervision. Interview conducted on February 13, 2015 with Staff #105 who reported that Resident #41 requires 1 person assist with toileting; able to indicate when needs to have a bowel movement but continence of bowel varies; is incontinent of urine; and wears an incontinence product 24/7.

Review of Resident #41 plan of care found no evidence related to continence level and use of incontinence product; or ability to indicate the need to use the washroom periodically.

Interview conducted with the Director of Care (DOC) on February 13, 2015 who reported that a resident's level of incontinence and need to wear an incontinence product should be identified on the care plan. The DOC reported a review of Resident #41's plan of care found no evidence of continence level, the use of incontinence products, and/or related interventions. [s. 6. (1) (c)]

4. The plan of care for Resident #06 under falls focus identifies that the resident has been assessed as high risk of falling and directs staff to ensure side rail closest to the window is up while in bed for bed mobility.

Interviews with Staff #113 and #120 indicated that the Resident #06 uses one bed rail when in bed.

Interviews with Staff #111 and #133 confirmed that Resident #06 is found in the morning in bed with two bed rails kept in up position. Both rails are used due to risk of falling and to assist in turning in bed with some help from staff.

On February 18, 2015 at 07:43 hrs Inspector observed Resident #06 in bed with two half bed rails in the upright position; bed was not in lowest position; foot of bed was raised elevating the foot end of the mattress. Staff #120 confirmed that the two bed rails were in upright position and the bed was not in lowest position when resident was in bed.

The plan of care did not give clear direction to staff providing care regarding the use of the bed rails for Resident #06. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the resident was 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

Review of the most recent full assessment completed August 15, 2014 for the resident indicates that the resident does not speak, rarely/never understands others and that there is now a deterioration in the resident's communication status.

During the inspection, Inspector # 552 attempted to speak with the resident but received no response.

Interview with Staff # 112, 115 and 118 all explained that the resident used to be able to verbally respond to simple questions but that the resident no longer speaks.

Review of the care plan directs the staff to ask questions that require yes or no answers. The care plan does not address the fact that the resident's communication status has deteriorated. [s. 6. (10) (b)]

6. Review of current care plan for Resident # 32 indicates that 3/4 bed rails (x 2) is required to assist with repositioning and bed mobility due to impaired mobility and impaired cognition.

Interview with Staff # 112, 115 and 118 explained that side rails were used initially for the resident because the resident used to be able to hold on to the side rails to assist with bed mobility. The resident's condition has now deteriorated and is unable to hold on to rails. The resident is being turned and repositioned every 2 hours by staff and requires total assistance.

The DOC stated that the resident's SDM's requested the bed rails be used and would expect that the care plan should reflect the reason for use of the bed rails. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident sets out the planned care, clear directions to staff and others 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 #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations made during Initial Tour on February 9,2015 found:
Lakeridge Crescent:
- Crack in wall from ceiling down to mid wall in hallway
- Unfinished dry wall repair in hallway
- Dry wall damage next next to room 1119 door.
- Dry wall damage with cracks in dry wall above exit door #B1.
- Dry wall damage at bulk head next to room 1117.
- Spa room: Dry wall damage (12 x 24 inches) in bulk head above sink.
- Spa room # GN 33: Black marks on lower wall next to sink; Broken soap dispenser next

to sink
Exposed and rusty corner bead at lower corner next to sink; Damaged/rusty lower corner beads in shower area.
Harwood Lane:
- Shower area GS-30: Damage to lower corner next to toilet area; Water damage to dry wall above sink area; Damage to dry wall in ceiling in corner in shower area.
- Spa room (west): Damage to lower corner next to sink; Damage to dry wall ceiling above shower area.

Westney Heights:
- Visitors bathroom walls cracked with drywall damage and peeling paint

Bayley unit:
- Shower area: Damage to base board next to sink
- Spa room 2S-59: Cracks in floor in sink area

Observations made of Resident rooms and washrooms on February 11,2015 found:
Resident #28: exposed drywall to wall close to washroom
Resident #10 : baseboard is loose at door frame of bathroom; gap in carpet seams in bed room
Resident #18 : scuff of wall with scrapped/peeled paint exposed from window to corner and corner onwards, approx 5 ft; missing wall cover/protector in corner at entry to washroom, exposed sheet rock in washroom below toilet arm and both entry way corners; splatter on wall below washroom sink; scuffed wall with chips on plaster along entry way wall.

Interview conducted with Staff #116 on February 17, 2015 who reported was responsible for major cleaning and simple plaster/paint repair throughout the building. Staff #116 reported in order to determine repairs needed Staff #116 does own tour of the home on daily basis, speaks with nursing staff regarding any repairs/issues, and takes direction of issues from ESM related to repairs and painting to be completed. Staff #116 also follows a weekly and monthly schedule related to cleaning duties, repairs and painting.

Review of procedure entitled “Nova: Staff Daily Cleaning Routines – Heavy Duty Cleaner #1 B-15-30” indicated “Complete paint touch-ups according to the monthly schedule HKG B-15-30 page 3.” Review of document entitled “Nova: Monthly Deep Cleaning Schedule HKG B-15-30 page 3” indicated “Paint – 1st Floor” and “Paint – 2nd Floor” on alternating months; and “Touch-up painting every 2 months”.

Interview conducted with ESM on February 17,2015 who reported that nursing or

housekeeping staff notify Maintenance of needed repairs electronically and verbally which the ESM then prioritizes for completion. The ESM reported that a daily inspection is done of the home and he also speaks with nursing regarding any maintenance issues. The ESM reported that a full paint and plaster repair is done when a room is empty, and the periodic repairs are done as needed on occupied rooms. Common areas are repaired and painted as needed. The ESM reports that the procedure entitled "Nova: Quarterly Routines - Painting", E-75-15 is used related to painting and repairs, and that a complete home paint schedule was developed in January 2015, prior to this date there was no painting schedule available. The ESM reports he has started a painting program but has not completed identified items for January 26 and February 2, 2015 as per painting schedule developed on January 21, 2015.

Review of procedure entitled "Nova: Quarterly Routines – Painting" E-75-15 indicates:
"The ESM or designate is required to inspect the home on a monthly basis and follow-up with painting where required."
"All areas of the home will be touch-up painted at least quarterly and recorded on this form. Once the form is completed it is to be placed in the Preventative Summary Binder."

The ESM was unable to provide evidence related to monthly inspections or that all areas of the home have been painted at least quarterly.

Interview conducted on February 17, 2015 with the Executive Director (ED) who reported that all home maintenance is handled by a service provider and therefore the home uses the service provider's procedures. The Administrator provided the service provider's Quality Management Audit Summary dated August 12, 2014 which indicated wall repair and paint deficiencies to be completed by years end. The ED reports she is aware of the home repair and painting issues having not being completed as required, and it is been addressed with the recent development of an action plan and painting schedule. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents using bed rails were assessed and their bed systems evaluated in accordance with evidence-based practices to minimize risk to residents.

Resident #06 was observed to have both bed rails in the raised position when in bed. Interview with staff indicated that Resident #06 used one or two bed rails in up position when in bed for safety and to assist in turning in bed.

Residents #10 and #44 were observed to have both bed rails in the raised position when in bed. Staff interviews indicated the use of two bed rails in up position for Residents #06 and #44 when in bed on request.

Review of clinical records of Resident #06, #10 and #44 did not include an assessment

of the resident related to use of bed rails.

The home's policy (Side Rails: index: LTC-K-10-ON, effective date: October 2013) identifies: All residents using side rails will be assessed for the need for side rails and the associated risks with the utilization of side rails [Side Rail and Alternative Equipment Intervention Decision Tree].

The home's policy (Resident Bed Systems/Entrapment: index: LTC-K-25, revised date: November 2014) identifies:
- Bed systems will meet resident's assessed need and be maintained to ensure resident safety by eliminating entrapment points.
- Bed system encompasses the bed frame, side rails, head and foot boards, mattress and any ancillary accessories.
- All bed systems will be evaluated annually (at a minimum) for zones of entrapment.
- All residents using side rails will be assessed for potential risks of entrapment.

Interview with the DOC indicated that the expectation of the home is that staff will assess the need for using bed rails for each resident using the Side Rail and Alternative Equipment Intervention Decision Tree algorithm and the use of bed rails be documented in the plan of care.

The DOC confirmed there is no documented evidence that Residents #06, #10 and #44 were assessed for the use of bed rails nor the bed systems for these residents evaluated in accordance with evidenced-based practices to minimize the risk to the residents. Registered staff did not complete the Side Rail and Alternative Equipment Intervention Decision Tree for each resident. [s. 15. (1) (a)]

WN #4: 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 Residents' Council receives a response in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

The minutes of three Residents' Council meetings were reviewed. In each of the minutes reviewed, the Residents' Council has concerns or recommendations. For example:

In the minutes of the October 15, 2014 meeting, it indicates that the Residents' Council had a concern regarding the temperature of the building. The action was to inform the Environmental Service Manager (ESM) for follow-up.

In the minutes of the November 7, 2014 meeting, the Residents' Council requested that a microphone and speakers be used for entertainment venues. The action was to forward on to Recreation Manager.

In the minutes of the January 30, 2015 meeting, the Residents' Council had a concern regarding a shortage of face cloths. The action was to forward the concern to the ESM and DOC for follow up and revisit at next meeting.

The assistant to the Residents' Council was interviewed and stated that when a concern is raised, she discusses the issues at the managers' morning report the following day. An email response is then sent to the assistant to the Residents' Council from the appropriate manager and is discussed at the next Residents' Council meeting.

The assistant to the Resident's Council did not provide any documentation to support that the manager's email response was received within 10 business days or that this was the Residents' Council preferred method of addressing their concerns or recommendations. [s. 57. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

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

On February 19, 2015 during an interview, the Family Council representative indicated the Family Council does not receive a written response to concerns brought forward. All concerns directed to the licensee by the Family Council have been addressed verbally and recorded in the next meeting’s minutes.

Review of the Family Council Meeting minutes from October 16, 2014 to January 22, 2015 indicated the following concerns with no written response provided:
- Minutes from October 16, 2014 had a concern that the table rotation is not being followed on Harwood residents’ home area.
- Minutes from January 22, 2015 had the following concerns: Nursing concern related to time allotted per resident for care related to showering/bathing; A concern that garbage bags with soiled briefs were kept in clean cart closet; Dietary concerns that the clear thickener is not always available and the nourishments were not labeled on the snack cart on January 12, 2015; a request for more programing on Lakeridge home area such as finger painting, kinetic sand and more Montessori activities.

Interview with the Executive Director confirmed that concerns brought forward by the Family Council are discussed and responded to at the next meeting but no written responses are provided. [s. 60. (2)]

WN #6: 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's complaint related to missing money was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

On an identified date, Resident #33 reported missing money to Staff #124. Staff #124 documented the incident in progress notes and the manager on-call manager was informed of the incident.

On an identified date Staff #132 spoke to Resident #33 regarding the missing money. Staff #132 documented that the resident's verbal statement was recorded and the resident declined police involvement. The resident was informed that an internal investigation will be conducted.

Licensee's policy (Index: LP-B-20) directs any verbal concerns/complaints not resolved immediately to be recorded on a Client Services Response form (CSR) and forwarded to the Executive Director. The person who raised the initial concern will be informed of the actions within 2 business days and the investigation should be conducted and the issue resolved within 10 business days. The CSR is then filed in the complaints management binder.

Review of the home's CSR reports/complaints of 2014 indicated no evidence of a CSR form completed and no evidence of an investigation conducted related to Resident #33's complaint of missing money. The incident was not recorded in the CSR reports/complaints log binder.

On February 19, 2015 during an interview Staff #132 indicated that she is not aware if an investigation was completed in relation to missing money and that Resident #33's written statement was forwarded to the DOC who is no longer employed by the home.

On February 19, 2015 during an interview, the Executive Director indicated that she was not aware of missing money complaint from Resident #33 and unaware if an investigation was completed. [s. 101. (1) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals.

Interview with Staff # 116 indicated that she does administer ointments but received no training. This information was also confirmed by Staff # 100,115 and 127 who work on different units.

Interview with Director of Care who explained that the Registered Staff is supposed to provide training to the Personal Support Workers on the administration of topicals. The DOC was unable to confirm that this has been done and has no record to confirm that the Personal Support Workers did receive training. [s. 131. (4)]

WN #8: 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:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

The home’s Tuberculosis Screening – Resident Policy Index: IPC-I-20 revised November 2013 indicates "The screening for tuberculosis and reporting of positive results will be conducted in accordance with Canadian Infection Prevention and Control standards and provincial/regional requirements”

In an interview the DOC indicated that the home follows the local Public Health Unit (PHU) recommendations for TB screening to be completed within 14 days of admission. The PHU recommendations include:
- Chest x-ray taken within 90 days prior to admission to the home. If the x-ray was not done within 90 days prior to admission, it should be taken within 14 days of admission.
- Tuberculin skin test (TST), a 2 step TST is recommended for residents < 65 years of age.

Review of health records for Resident #42 indicated that the resident was admitted on an identified date and there is no evidence that TB screening was completed for Resident #42 within 14 days of admission or that the resident had been screened 90 days prior to admission.

On February 19, 2015, the DOC and Staff #101 confirmed that no evidence of TB screening was completed for Resident #42.

The DOC indicated that the expectation of the home that Resident #42 should have been screened for TB within 14 days of admission. [s. 229. (10) 1.]

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.