Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

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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
Apr 27, 2015	2015_157210_0007	T-1768-15	Resident Quality Inspection

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET TORONTO ON M5A 2S3

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

WELLESLEY CENTRAL PLACE
160 WELLESLEY STREET EAST TORONTO ON M4Y 1J2

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

SLAVICA VUCKO (210), SARAH KENNEDY (605), STELLA NG (507)

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): March 26, 27, 30, 31, April 1, 2, 3, 6, 7, 8, 2015

The following complaint intake inspection was completed during this inspection: T-672-14, T-472-14, T-567-14,T-664-14

During the course of the inspection, the inspector(s) spoke with personal support workers(PSW), registered practical nurses (RPN), registered nurses (RN), acting executive director, director of nursing service(DONS), director of clinical services and education(DOC), acting director of clinical services and education, physiotherapist (PT), dietary aid, food services supervisor, food services manager, environmental services manager, housekeeping aid, RAI MDS coordinator, private care givers, residents, families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

12 WN(s)
3 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. 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:
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 the resident's right to have his or her personal health information within the meaning of the Personal Health Promotion Protection Act, 2004 kept confidential in accordance with that Act is fully respected and promoted.

On March 26, 2015, the inspector observed the following licensee inspection reports were kept in a wall-mounted tray located in the hallway of the main floor in front of the administration office:

- Five copies of 2013_241502_0002,
- Four copies of 2014_357101_0038,
- One copy of 2014_357101_0053, and
- 29 copies of 2013_241502_0002.

Review of the above mentioned licensee inspection reports revealed that the reports contain residents' personal health information.

Interview with the Acting ED and the DNS confirmed that the above mentioned licensee inspection reports contain residents' personal health information and they should not be accessible by the public. [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 the resident's right to have his or her personal health information within the meaning of the Personal Health Promotion Protection Act, 2004 kept confidential in accordance with that Act 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Interview with an identified PSW indicated that resident #18 is at high risk for falls and he/she usually checks the resident before and after breakfast and lunch to see if he/she needs assistance with toileting. The resident is confused, trying to get up by him/her self, and not calling for assistance. The resident has the urge to go to the toilet and needs frequent toileting.

Review of the written plan of care indicated the resident to be toileted 30 minutes after

meals, at bed time and as needed and was updated on identified date. The previous care plan indicated the resident had to be toileted every two hours.

Review of the clinical record indicated the resident had six falls in the period of six month. During one of the falls, one month after the admission, he/she sustained a fracture.

Interview with the registered nursing staff confirmed he/she was not informed that the resident was assisted with toileting before and after meals, in order to update the care plan. During the inspection, the registered nursing staff updated the written plan of care the resident to be toileted every two hours. [s. 6. (4) (a)]

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.

Review of the written plan of care indicated resident #18 uses a wheelchair for mobility and he/she needs one person assistance with mobility.

Interview with the physiotherapist revealed the resident was assessed at admission. The assessment revealed the resident had unsteady gait and required the use of the wheelchair for all mobility.

Review of the progress notes indicated on an identified date, the resident was assisted with toileting four times at night using the walker to ambulate to the toilet.

Interview with identified private care giver indicated the resident is able to use the walker that is located in the resident's room for ambulation and he/she is more independent to walk with assistance of staff and using the walker than five to six months ago. Interview with identified PSW indicated that there are occasions when he/she is assisting the resident with walking to the bathroom using the walker, and for mobility from the room to the dining the resident is using a wheelchair.

Interview with the physiotherapist and director of clinical services and education who is the lead of the falls management program confirmed that the resident should be using the wheelchair only for ambulation and that the care plan was not followed. [s. 6. (7)]

3. The licensee has failed to ensure that the following are documented: the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, the effectiveness of the plan of care.

Observation on an identified date in 2015, indicated resident #41 was on main floor and there was strong odour. This was confirmed with the acting executive director. Observation of the resident room at 1:15 p.m., the same day, revealed strong smell of urine and urine on the floor. Interview with identified PSW indicated the resident is sometimes incontinent of urine, he/she is hoarding items from other residents and putting them in his/her pants, and refusing care such as shower.

Review of clinical record for one month in 2015 indicated the resident refused shower during two occasions.

Interview with registered nursing staff indicated whenever the resident has responsive behaviour such as refusing care/shower, to be reported to the registered staff and perform further assessments as required.

Review of the written plan of care indicated the clothes to be changed every day and make sure they are clean.

Review of the flow sheets, the clinical record and interview with registered nursing staff confirmed there was no documentation that the resident refused the clothes to be changed on the day of observation or the shower was refused, and what further interventions were tried according to the written plan of care. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care set out in the plan is no longer necessary.

Review resident #16's Point of Care (POC) and progress notes between July 2014 and March 2015, and the MDS assessment from a specified date, revealed that the resident did not have any verbal and physical aggressive behaviours. Review of the recent resident #16's written plan of care revealed that the resident requires interventions to reduce incidents of aggression and to ensure the safety of the residents and staff because of her verbal and physical aggressive behaviours.

During the course of inspection, the inspector observed resident #16 not having any verbal or physical aggressive behaviours.

Interviews with an identified PSW and an identified registered staff confirmed that

resident #16 has not had any verbal and physical aggressive behaviours in the last eight months. The identified registered staff also confirmed that the resident's plan of care was not reviewed and revised when the interventions for her verbal and aggressive behaviours were no longer necessary. [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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the care set out in the plan of care is provided to the resident as specified in the plan, the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted as required.

On March 26, 2015, the inspector observed the following inspection reports were not posted in the home:

- 2013_162109_0029 dated June 13, 2013,
- 2013_162109_0027 dated June 17, 2013,
- 2013_241502_0002 dated January 6, 2014,
- 2014_157210_0007 dated June 10, 2014,
- 2014_357101_0022 dated June 11, 2014,
- 2014_357101_0038 dated September 22, 2014, and
- 2014_357101_0053 dated November 28, 2014.

The absence of the above mentioned inspection reports was confirmed in an interview with the Acting ED and the DNS. [s. 79. (3) (k)]

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 copies of the inspection reports from the past two years for the long-term care home are posted as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Self Administration of Medications policy is complied with.

Review of the home's Self Administration of Medication policy, index #:F-40, revised on July 30, 2014, indicates that the process in assessing the resident's ability to self-administration of medications include assessing the resident's capacity to self-administer his/her medications prior to receiving the order to "self-medicate", and re-assessing the resident's ongoing cognitive and physical ability to self-administer his/her medications at a minimum weekly.

On April 1, 2015, the inspector observed three medications were kept in one of the resident's rooms.

Review of the resident's health record revealed that resident #15 was admitted to the home on an identified date in 2014. Review of the physician's admission notice/orders dated two days after the admission, revealed that the physician ordered the above mentioned medications may be kept by the bedside.

Review of the resident's health record, physician's orders, progress notes, E-MAR and plan of care revealed that the resident was not assessed for his/her capacity to self-administer his/her medications prior to receiving the order to "self-medicate", and the resident was not re-assessed of her ongoing cognitive and physical ability to self-administer his/her medications at a minimum weekly.

Interview with the DNS confirmed that resident #15 was not assessed for his/her capacity to self-administer his/her medications prior to receiving the order to "self-medicate", and the resident was not re-assessed of his/her ongoing cognitive and physical ability to self-administer his/her medications. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment is kept clean and sanitary.

On an identified date observed that resident #005's wheelchair was soiled with white particles. At another date, resident #005's wheelchair continued to be soiled and in addition was covered with spilled liquid and dried food.

Interview with an identified PSW, confirmed that resident #005's wheelchair was soiled. It was stated that the night PSWs are responsible for cleaning wheelchairs on a weekly basis as per a schedule and that wheelchairs should be cleaned as needed if found dirty. Interview with an identified registered staff member confirmed that this is the expectation.

Review of the "Equipment Cleaning Schedule" revealed that resident #005's wheelchair was supposed to be cleaned on an identified date, during the night shift.

Observation, record review and interviews with the identified staff members confirmed that the wheelchair for resident #005 was not kept clean and sanitary. [s. 15. (2) (a)]

2. On an identified date, inspector #605 observed that resident #16's wheelchair had white stains on the back cushion and arm rests. On another date, inspector #507 observed that the white stains remained on resident #16's wheelchair.

Review of the "Equipment Cleaning Schedule" revealed that resident #16's wheelchair was supposed to be cleaned on identified dates, once weekly.

Interview with an identified registered staff indicated that the expectation is for staff to follow the wheelchair cleaning schedule and to clean equipment as needed if found unclean. The identified registered staff confirmed that resident #16's wheelchair was not kept clean and sanitary. [s. 15. (2) (a)]

WN #6: 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 ensure that the home responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Interview with an identified representative of the Family Council revealed that the licensee does not respond in writing within 10 days of receiving advice or concerns addressed at the Family Council meetings.

Interview with the Acting Executive Director confirmed that a response in writing was not provided within 10 days of receiving advice/concerns from the Family Council. [s. 60. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the height for every resident is measured annually.

Record review revealed that the following residents have not had their height measured since the following dates:

#020 – October 2012
#011 – October 2012

Interview with the Director of Nursing Services confirmed that the expectation is for residents' heights to be measured annually, and the above mentioned residents did not have their annual height measured. [s. 68. (2) (e)]

WN #8: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menus are communicated to residents.

On March 26, 2015, at 12:00 p.m., during meal service, it was observed that the posted weekly menu did not match the posted daily menus or what residents were being served for lunch.

An identified registered staff member confirmed that the correct weekly menu was not posted. Interview with the Food Service Manager confirmed that the expectation is for the updated weekly menus to be posted.

Observation and interviews with the identified staff members confirmed that the weekly menus were not communicated to residents. [s. 73. (1) 1.]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide them with assistance.

On an identified date, during lunch time meal service, it was observed that resident #022 was served both his/her main course and dessert before a staff member was able to assist this resident with eating.

Interview with an identified PSW confirmed that resident #022 is total care and requires assistance with meals. The same staff member confirmed that resident #022 was served both his/her main course and dessert before someone was able to assist this resident.

Interview with the Director of Nursing Services stated that the expectation is for residents who require assistance to receive their meals only when someone is available to assist with eating.

Observations and interviews with the identified staff members confirmed that a resident who requires assistance with eating and drinking was served a meal before someone was available to assist. [s. 73. (2) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey.

Interview with an identified representative of the Family Council revealed that the home does not consult with the Family Council on developing and carrying out the satisfaction survey.

Interview with the Acting Executive Director confirmed that a satisfaction survey in 2014 was not distributed to the Family Council. It was stated that a new satisfaction survey is being developed and this will be reviewed with the Family Council at an upcoming meeting. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Residents' Council is sought in developing and carrying out the satisfaction survey and in acting on its results.

Interview with the Acting Executive Director confirmed that a satisfaction survey was not sent to residents in 2014. It was confirmed that the advice of the Residents' Council was not sought in developing and carrying out the satisfaction survey as well as acting on its results. The satisfaction survey for the year 2015 was just completed. [s. 85. (3)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, the inspector observed a strong urine odor coming from one of the rooms which was apparent out into the corridor. The resident in the room was observed to be sitting on the bed with a urine spill on the floor.

Interview with an identified PSW indicated the resident is sometimes incontinent of urine and it could happen that he/she has incidents of urine or bowel movement on the floor or in the garbage bin. The resident is able to self-toilet but she does not always ask for assistance when using the toilet. Staff was not able to identify how often the resident should be assisted with toileting. The identified PSW indicated he/she would wipe out the bodily fluids from the floor and make sure he/she would sanitize it with Virox spray.

Interview with a family member indicated the resident is able to use the toilet but sometimes he/she is confused and not able to reach to the toilet.

Interview with DON indicated the resident is hoarder and he/she picks up other resident's dirty items and puts them in his/her pants or under his/her top. The resident has periods when he/she is more confused and he/she is not able to reach the toilet.

Interview with environmental staff indicated that the home has a schedule for deep cleaning of every room and it is performed once a week. If he/she notices that the particular room needs additional cleaning he/she would do it, but he/she does not have a routine or schedule.

Interview with DON confirmed there was offensive odor in the particular room and that the deep cleaning of the room is not enough to be performed once a week, and he/she will ensure that it is cleaned every day. [s. 87. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' personal items and clothing are labeled within 48 hours of admission and of acquiring, in the case of new clothing.

Observation performed on an identified date, indicated the resident had mismatching pair of shoes on him/her. Neither the shoe nor the slipper were labeled with the resident's name.

Interview with DOC indicated that whenever the family brings new clothes for residents, they have to fill out a clothing form and clothes get sent to laundry for labeling. He/she was not able to locate the clothing form for the shoes of resident #6.

Interview with the identified PSW confirmed that resident #6's shoes were not labeled. [s. 89. (1) (a) (ii)]

WN #12: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date, the inspector observed three medications were kept in resident #15's room.

Interviews with the resident and his/her spouse revealed that the resident self-administers two of the medications. They also revealed that the resident's spouse applies one medication to the resident's skin twice daily.

Review of the physician's order indicated that the above mentioned medications have not been approved by the physician for self-administration.

Interview with the DNS revealed that the above medications were kept in resident #15's room, so that the resident's spouse can administer two of the medications to the resident. The DNS confirmed that the above mentioned medications were not approved for self-administration in consultation with the resident. [s. 131. (5)]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.