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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 4, 2014	2014_332575_0008	S-000217-14	Resident Quality Inspection

Licensee/Titulaire de permis

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

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

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

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

LINDSAY DYRDA (575), MARSHA RIVERS (576), VALA MONESTIMEBELTER (580)

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): June 10, 11, 12, 13, 16, 17, 18, 19, 20, 2014

This inspection addresses both the Lakeland Long-Term Care Home #2958 and ELDCAP #2966. Additionally, Critical Incident #2966-000001-14 Log #S-000153-14 was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant/Acting Director of Care (ADOC), Registered Nursing Staff, Personal Support Workers (PSW), Recreation Workers, Behaviour Response Team (BRT), Director of Environmental Services, Manager of Support Services, Dietary Aides, Housekeeping Staff, Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a daily walk-through of the home, made direct observations of the delivery of care and services to residents, reviewed
resident health care records, and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On June 16, 2014 inspector #575 reviewed the home's Mantoux Skin Testing policy

dated July 2012. The policy indicated that all residents admitted to the home will have a 2-step TB skin test initiated within 14 days of admission. The policy further indicated that the 1st step should be completed within the first week of admission and read 48 to 72 hours after test is administered. The 2nd step should commence 7 to 28 days after the first step was initiated.
On June 16, 2014 inspector #575 reviewed the immunization records for resident's #5295, #5357, and #5359.
Resident #5295 was admitted to the home in 2005. Records indicate that resident #5295's 1st step TB test was not initiated until 2006, more than 14 days after admission. Further, the immunization record does not indicate what date the test was read.
Resident #5357 was admitted to the home in 2012. Records indicate that resident #5357's 1st step TB test was initiated in 2012 however the immunization record does not indicate what date the test was read. The 2nd step was initiated and read on the same day in 2013.
Resident #5359 was admitted to the home in 2012. Records indicate that resident #5359's 1st step TB test was initiated and read on the same day in 2012. Further, the 2nd step was initiated and read on the same day in 2012 and more than 7 to 28 days after the first step was initiated.
The licensee did not ensure that its policy for Mantoux Skin Testing dated July 2012, was complied with, in that it failed to ensure that all residents admitted to the home had a 2-step TB skin test initiated within 14 days of admission and that test was initiated and read within the specified timeframes. [s. 8. (1)]

2. On June 17, 2014 inspector #580 reviewed the home's General Policy – Medication Administration Times effective January 2010 which states that no person except a Physician, Dentist, RN or RPN, shall administer a drug to a resident.
On June 13, 2014 inspector #580 interviewed staff member #100 regarding the administration of topical medication. Staff member #100 advised inspector #580 that non-registered staff apply medication on residents' skin. The staff member further indicated that registered staff show the PSWs how to apply the creams, how to report back on skin changes, how to document and ensure that the PSWs report back to the registered staff after applying the medicated creams.
On June 17, 2014 staff members #101 and #102 confirmed to inspector #580 that PSWs are given creams to apply to residents. On June 17, 2014 staff members #200, #201 and #202 confirmed to inspector #580 that non-registered staff members apply medicated creams to residents as per instructions from the registered staff.
The licensee did not ensure that its policy for Medication Administration Times

effective January 2010, was complied with, in that it failed to ensure that no person except a Physician, Dentist, RN or RPN, administers a drug to a resident. [s. 8. (1)]

3. Inspector #576 reviewed the home's Skin and Wound Care policy #RSL-DOC-035. The policy states that registered staff are responsible for conducting quarterly skin assessments. The ADOC confirmed with inspector #576 that the quarterly skin assessment completed by registered staff includes a Braden Scale risk assessment and a head to toe skin assessment.
Inspector #576 reviewed the health care records for resident #5301 and was unable to locate a head to toe skin assessment completed in the past 6 months. Inspector #576 confirmed with registered staff member #101 and the ADOC that a head to toe skin assessment was not completed for resident #5301 in the past 6 months.
The licensee failed to ensure that its Skin and Wound Care policy #RSL-DOC-035 was complied with, in that it failed to ensure that a quarterly head to toe skin assessment was completed by a registered staff. [s. 8. (1) (a),s. 8. (1) (b)]

4. Inspector #576 reviewed the home's Skin and Wound Care policy #RSL-DOC-035. The policy states that registered staff are responsible for conducting quarterly skin assessments. The ADOC confirmed that the quarterly skin assessment by registered staff includes a Braden Scale risk assessment and a head to toe skin assessment using the assessment instruments on MEDe-Care. Inspector #576 reviewed the health care records for resident #5335 for a period of approximately 6 months and noted that during this period, a head to toe assessment was not completed and the Braden Scale risk assessment was completed only one time during this period.
The licensee failed to ensure that its Skin and Wound Care policy #RSL-DOC-035 was complied with, in that it failed to ensure that a quarterly head to toe skin assessment and Braden Scale risk assessment was completed by a registered staff. [s. 8. (1) (a),s. 8. (1) (b)]

5. Inspector #576 reviewed the home's Skin and Wound care policy #RSL-DOC-035. The policy states that registered staff are responsible for conducting quarterly skin assessments. The ADOC confirmed that the quarterly skin assessment by registered staff includes a Braden Scale risk assessment and a head to toe skin assessment using the assessment instruments on MEDe-Care. Inspector #576 reviewed the health care records for resident #5339 for a period of approximately 6 months and noted that during this period, a head to toe skin assessment was completed only one time during this period.
The licensee failed to ensure that its Skin and Wound care policy #RSL-DOC-035 was

complied with, in that it failed to ensure that a quarterly head to toe skin assessment was completed by a registered staff. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. On June 19, 2014 inspector #575 completed an audit of the Infection Prevention and Control staff training records for 2013 and 2014. The training records were compared to the number of current staff as per the ADOC. Training records for hand

hygiene, modes of infection transmission, cleaning and disinfection practices and use of personal protective equipment were reviewed. It was determined that only 12/149 staff or 24.5% of staff completed hand hygiene, 54/149 staff or 36.2% of staff completed modes of transmission and personal protective equipment, and 24/149 staff or 16.1% of staff completed cleaning and disinfection. Additionally, only 72/149 staff or 48.3% of staff completed online infection control training and 12/149 staff or 8.1% of staff completed online training for personal protective equipment.
The licensee did not ensure that all staff at the home receive training and retraining in infection prevention and control as required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act including hand hygiene, modes of infection transmission, cleaning and disinfection practices, and use of personal protective equipment. [s. 76. (2) 9.]

2. Inspector #576 completed an audit of the Restraints Program staff training records for 2013 and 2014. The training records were compared to the current staff list provided by the home. Training for direct care staff including RNs, RPNs, and PSWs was reviewed. Inspector #576 noted that training on minimizing of restraining of residents during this period included the following:
-in 2013, only 1/7 RNs, 7/24 RPNs, and 14/81 PSWs completed the online surge learning course for "restraint use";
-in 2014, only 0/7 RNs, 6/24 RPNs, and 0/81 PSWs completed the online surge learning course for "minimizing of restraints";
-in 2014, only 0/7 RNs, 3/24 RPNs, and 19/81 PSWs completed the online surge learning course for "reducing restraints"; and
-in 2014, only 0/7 RNs, 0/24 RPNs, and 19/81 PSWs completed the online surge learning course for "restraint use".
The licensee did not ensure that all staff who provide direct care to residents receive training and re-training annually on minimizing the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. [s. 76. (7) 4.]

3. Inspector #576 completed an audit of the Skin and Wound Care Program staff training records for 2013 and 2014. The training records were compared to the current staff list provided by the home. Training for direct care staff including RNs, RPNs, and PSWs was reviewed. Inspector #576 noted that training on skin and wound care during this period included the following:
-on April 22, 2013, only 1/7 RNs, 0/24 RPNs, and 0/81 PSWs attended the RNAO Webcast "Mananagment of Stage 1 to Stage IV Pressure Ulcers";

-on November 6, 2013, only 0/7 RNs, 2/24 RPNs, and 18/81 PSWs attended training on "Footcare";
-on March 31, 2014 only 5/7 RNs, 10/24 RPNs, and 18/81 PSWs completed a questionnaire "Catch the Wave"
-on January 14, 2014, only 1/7 RNs, 2/24 RPNs, and 0/81 PSWs attended an in-house training on "Chronic Wounds in LTC"; and
-on April 16, 2014, only 0/7 RNs, 0/24 RPNs, and 17/81 PSWs completed the online surge learning module on "Prevention of Pressure Ulcer Training".
The ADOC confirmed training on various skin and wound care topics was poorly attended by direct care staff and that annual retraining on the home's skin and wound care program was not provided by the home to direct care staff.
The licensee did not ensure that all staff who provide direct care to residents receive training and re-training annually on skin and wound care. [s. 76. (7) 6.]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. On June 10 and 19, 2014, inspector #576 observed resident #5339 seated in a wheelchair with a restraint in place. Inspector #576 interviewed resident #5339 regarding the use of the restraint. Resident #5339 confirmed the restraint is always fastened when the resident is in the wheelchair. Inspector #576 reviewed health care records for resident #5339 and noted that the care plan does not provide direction with respect to the use of a wheelchair restraint. Staff #203 and #204 confirmed that the direct care staff obtain plan of care information and direction from the resident's care plan.
The licensee did not ensure that the written plan of care for resident #5339 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. On June 12, 2014 inspector #575 reviewed resident #5353's current MDS assessment. The assessment identifies the resident as having an active disease. On June 13, 2014 inspector #575 interviewed staff member #104 who stated that resident #5353 has not had this active disease or any other related type of disease since admission to the home. Inspector #575 further reviewed the MDS assessments from admission to present day. Inspector #575 identified that 9/11 assessments continually identify the resident as having the disease. On June 16, 2014 the ADOC confirmed that coding the resident as having the disease was an error and that once it is coded it automatically gets filtered into the next assessment.
The assessment of resident #5353, on which the plan of care is based, continues to identify the resident as being diagnosed with an active disease, however, this is not accurate.
The licensee did not ensure that the plan of care is based on an assessment of resident #5353 and the resident's needs and preferences. [s. 6. (2)]

3. Inspector #576 reviewed the health care records for resident #5339. Inspector #576 noted that in the resident's care plan, under the problem "sad, depressed or withdrawn", the care plan states that this problem is related to a decline in mobility due to a fracture and an aging sick spouse at home. Under the problem "grieving/loss", the care plan states that this problem is related to the death of the resident's spouse in 2013. Inspector #576 reviewed the RAPs report for the annual RAI-MDS assessment. Under the triggered RAP for "psychosocial well-being", it indicates that the resident's spouse lives in the long-term care home on another home area and they visit when possible. Staff #201 confirmed that resident #5339's spouse did live in the home but passed away. The assessment of resident #5339, on which the plan of care is based, continues to identify that the resident's spouse resides in the home, however, this is not accurate.

The licensee failed to ensure that the plan of care was based on an assessment of the resident #5339 and the resident's needs and preferences. [s. 6. (2)]

4. On June 19, 2014 inspector #580 reviewed resident #5317's care plan regarding mouth care. The care plan indicated that staff are to encourage the resident to do mouth care every morning and evening, swab the resident's mouth after meals and in the evening with antiseptic solution to decrease pain and discomfort (for a total of four times a day) and the dentist indicates to use antiseptic wash regularly.
On June 19, 2014 inspector # 580 interviewed staff member #205 regarding mouth care for resident #5317. Staff member #205 indicated that resident #5317 receives mouth care with a dental rinse three times a day.
On June 19, 2014 inspector #580 reviewed the Observation/Flow Sheet Monitoring Form for a period of approximately 1 month which indicated that resident # 5317 received personal hygiene (including mouth care) three times per day except on 4 occasions when it was given once a day and on 7 occasions when it was given twice a day.
On June 19, 2014 inspector #576 conducted an interview with staff members #203 and #204 who confirmed that PSWs refer to the residents' care plans for information on the residents' plan of care.
The licensee did not ensure that the care set out in the plan of care was provided to resident #5317 as specified in the plan. [s. 6. (7)]

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 ensuring that the written plan of care for resident #5339 set out clear directions to staff and others who provide direct care to the resident, that residents #5353 and #5339's plans of care are based on an accurate assessment of resident and the resident's needs and preferences, and that care is provided to resident #5317 as specified in the plan of care, to be implemented voluntarily.

WN #4: 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. On June 10, 2014 inspector #580 observed stained carpets throughout the home, stained floors in the tub areas of Georgian Bay and Snug Harbour, layers of dust on wheelchair foot rests in the tub areas of Snug Harbour, feces-like material on a commode chair in Snug Harbour.
On June 12, 2014 inspector #580 observed the Georgian Bay and Snug Harbour tub room, shower room, and common bathroom. Inspector #580 noted dirty towels on the floor, a falls mat on the floor, hair in the tub, stained floors, a commode soiled with feces-like material, and layers of dust on wheelchair foot rests on the floor.
On June 18, 2014 inspector #580 reviewed the home's Housekeeping Procedures Manual dated May 4, 2012 revised February 2013, and found no information on cleaning the tub areas, commode chairs, shower chairs or removing carpet stains.
On June 18, 2014 staff members #205, #206, #208, #209 and #106 confirmed to inspector #580 that the carpets are dirty on all home areas. Additionally, staff member #209 told inspector #580 that in the Snug Harbour tub room the floor is dirty and there is a dirty dish pan on the floor used to catch leaking water from the tub.
On June 19, 2014 staff member #302 told inspector #580 that the home does not have a policy on carpet cleaning, and although there is a policy that states that carpets will be cleaned annually, the policy did not apply to the home because it was a generic policy from Aramark (the cleaning company). Staff member #302 confirmed that two staff are trained on the carpet cleaner and spot treatment is performed. Additionally, the staff member stated that there is no formal auditing process for monitoring the home's cleanliness. The staff member explained that "walk-abouts" are performed daily but without formal documentation. Staff member #302 showed inspector #580 an audit spreadsheet used weekly that identified that on May 19, 30 and June 11, 2014 carpets in the Magnetewan, Lake Rousseau and Snug Harbour home areas have dirty spots that need to be cleaned.
The licensee did not ensure that, the home, furnishings and equipment are kept clean and sanitary and that the home, furnishings and equipment are maintained in a safe

condition and in a good state of repair. [s. 15. (2) (a)]

2. On June 12, 2014 inspectors #580 and #576 toured the home's four tub and shower areas and observed the following: in the Magnetawan home area the tub door seal is broken, the tub cannot be used and an urgent maintenance requisition on the tub was made and is dated February 26, 2014 however the tub remains broken; Snug Harbour home area's shower area walls have paint chipped off in a large sections, the shower chair cover is peeled away, the weight scale surface is torn; and in Georgian Bay home area the tub area has ripped flooring on the weight scale, a cracked, taped and worn shower chair, and gouged dry wall.
On June 17, 2014 inspector #580 interviewed staff member #301 regarding the responsibility of the maintenance department. The staff member stated the following
-the Georgian Bay tub area's ripped flooring on the weight scale is not the responsibility of maintenance to audit and the maintenance department has not received a maintenance request form for this;
-the Georgian Bay tub area's cracked, taped and worn shower chair is not the responsibility of maintenance to audit and the maintenance department has not received a maintenance request form for this;
-the Georgian Bay tub area's gouged dry wall is the maintenance department's responsibility but the maintenance department has not received a maintenance request form for this;
-the Snug Harbour shower area large area of chipped paint is the maintenance department's responsibility but the maintenance department has not received a maintenance request form for this;
-the Snug Harbour tub area shower chair cover in poor condition is not the responsibility of maintenance to audit and the maintenance department have not received a maintenance request form for this;
-the Snug Harbour tub area ripped/torn flooring on the weight scale is not the responsibility of maintenance to audit and the maintenance department has not received a maintenance request form for this; and
-the Magnetewan tub area tub cannot be used and there is an urgent maintenance requisition dated February 26, 2014, the maintenance department is aware of this and the Administrator has ordered a new tub that has not yet arrived (as of June 20, 2014).
On June 17, 2014 staff member #301 told inspector #580 that there is no audit process to check on completed requests, that the maintenance department only responds to initiated requests, and that he and the Administrator perform an annual walk-about to review the home's needs for repairs and/or paint. Staff member #301

confirmed to inspector #580 that the last walk-about was completed in November 2012.
On June 16 and 17, 2014, inspector #580 reviewed the Lakeland Maintenance Request Book for the following home areas: Georgian Bay, Magnetewan, Snug Harbour and Lake Rosseau. Inspector #580 found no requests for dry wall repair, paint repair or weight scale flooring repair and no maintenance requests related to the tub room or shower room from January 1, 2014 through to June 17, 2014.
The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary and that the home, furnishings and equipment are maintained in a good state of repair. [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 ensuring that the home, furnishings and equipment are kept clean and sanitary and that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Inspector #576 reviewed the health care records of resident #5301 for a period of approximately 6 months. Progress notes indicate that during this period staff observed two skin tears on resident #5301. Staff member #102 and the ADOC confirmed that when a skin tear is observed, registered staff are to complete a wound assessment using the wound tracker instrument on MedeCare. Inspector #576 noted that wound assessments were not completed for the skin tears observed by staff during this period.
The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin tears, receives a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. On June 11 and 18, 2014, inspector #576 observed an abrasion on resident #5335. Inspector #576 interviewed staff member #104 regarding resident #5335. The staff member stated that the resident currently has no wounds. When inspector #576 inquired about the abrasion, staff #104 observed the resident and stated that the abrasion was likely a skin tear. Inspector #576 reviewed the health care records of resident #5335 for a period of approximately 6 months. Progress notes make reference to multiple wounds. Only two wound tracker assessments were completed for this resident during this period. Inspector #576 noted that the abrasion to the resident was not documented in the progress notes and that a wound tracker report was not completed for this wound. The ADOC confirmed that initial wound assessments and weekly wound reassessments are to be completed by registered staff using the wound tracker instrument on MedeCare.
The licensee failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (i)]

3. On June 12 and 19, 2014, inspector #576 observed a wound on resident #5339. In an interview with staff member #109, the staff member stated that resident #5339 currently has multiple wounds. When inspector #576 inquired about the current wound observed, staff #109 was unaware that the resident had this wound. Inspector #576 reviewed the health care records of resident #5339 for the period of approximately 6 months. Wound tracker assessments were completed for one wound on 6 days during this period. Inspector #576 noted that no wound tracker

assessments were completed for 3 different wounds. The ADOC confirmed that initial wound assessments and weekly wound reassessments are to be completed by registered staff using the wound tracker instrument on Medecare.
The licensee failed to ensure that a resident exhibiting altered skin integrity, including pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [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 ensuring that a resident exhibiting altered skin integrity, including pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector #576 observed resident #5286 on two occasions and noted that the resident had long hairs on their chin and fingernails were long, chipped and unclean. The resident stated that they prefer short nails and to have their facial hair removed but require staff assistance. Inspector #576 reviewed the care plan and kardex for resident #5286 that indicates that the resident requires assistance for bathing and personal hygiene. Additionally, the care plan provides instruction to staff on how to provide assistance with morning and evening care and to check and clean resident #5286's nails twice per week on shower days and to trim their nails with nail clippers when needed. The ADOC confirmed that morning and evening care includes removal of facial hair.
The licensee failed to ensure that resident #5286's right to be properly groomed and care for in a manner consistent with his or her needs was fully respected and promoted. [s. 3. (1) 4.]

2. On June 10, 2014 inspector #576 observed resident #5301 wearing visibly soiled pants. Inspector #576 reviewed the care plan for resident #5301 and noted that the resident requires extensive assistance from 2 staff for dressing. Staff member #210 confirmed with inspector #576 that if a resident's clothing was to become soiled during the day, staff are to assist the resident to change clothes.
The licensee failed to ensure to ensure that resident #5301's right to be properly clothed and cared for in a manner consistent with his or her needs was fully respected and promoted. [s. 3. (1) 4.]

WN #7: 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. On June 12, 2014 inspector #575 reviewed the plan of care for resident #5309. The care plan indicated that when resident #5309 is in bed, side rails are to be in the upright vertical position for their safety and assistance with bed mobility and transfers. Inspector #575 was unable to locate a bed rail assessment. On June 14, 2014 inspector #575 interviewed the ADOC regarding bed rail assessments. The ADOC stated that the home does not complete a specific bed rail assessment using evidence-based practice and that the use of bed rails is determined by registered staff through their own clinical judgment.
The licensee did not ensure that where bed rails are used, the resident has been assessed and the bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On June 19, 2014 inspector #575 reviewed the home's concerns and complaints records for 2014. Inspector #575 noted a completed complaint investigation for an allegation of neglect of a resident. The record indicated that some of home's staff met with the resident's family to discuss the family's concerns. An investigation was completed by the home and another family meeting was conducted 9 days later. The home's staff reviewed the results of the investigation with the family.
On June 19, 2014 inspector #575 interviewed the Administrator who confirmed that the initial complaint was verbal. Additionally, the alleged neglect investigation was not reported to the Director. The Administrator reported to the inspector that they were not aware they needed to report the findings of the investigation to the Director.
The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a) of the LTCHA, 2007 S.O. 2007, c.8, s. 23. [s. 23. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. On June 13, 2014 inspector #575 requested a copy of the home's staffing plan for the nursing and personal support services program from the ADOC. On June 17, 2014 the ADOC confirmed with inspector #575 that the home does not currently have a written staffing plan. The licensee did not ensure there is a written staffing plan for the nursing and personal support services programs. [s. 31. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. On June 18, 2014 inspector #575 reviewed resident #5309's flow sheets from April 1, 2014 to June 18, 2014. The flow sheets indicated that the resident did not receive scheduled baths on April 7, 10, and May 1. The home's Personal Hygiene and Grooming policy indicates that all residents are to receive 2 baths, showers, or complete bed baths per week unless otherwise stated on their plan of care. Further, if a resident does not receive their scheduled bath, it is to be rescheduled as soon as possible. If the bath is not able to be rescheduled, registered staff are to document the reasons in the progress notes. Inspector #575 reviewed the care plan for resident #5309. The care plan indicated that resident #5309 is to receive 2 showers per week.

Inspector #575 reviewed the progress notes for April 7, 10, and May 1, 2014. Inspector #575 noted that there was no documentation to support why the showers were not given. Resident #5309 did not receive any showers during the week of April 6-12, 2014 and only received one shower during the week of April 27-May 3, 2014. The licensee did not ensure that resident #5309 was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)]

2. On June 19, 2014 inspector #580 reviewed the care plan for resident #5324 which indicated that the resident will remain clean and well groomed and receive 2 baths per week. Inspector #580 reviewed the flow sheets for resident #5324 from May 23 to June 18, 2014 and noted that resident #5324 had received 2 baths in 27 days and had refused 3 baths in 27 days.
The home's Personal Hygiene and Grooming policy indicates that all residents are to receive 2 baths, showers, or complete bed baths per week unless otherwise stated on their plan of care. Further, if a resident does not receive their scheduled bath, it is to be rescheduled as soon as possible. If the bath is not able to be rescheduled, registered staff are to document the reasons in the progress notes. Inspector #580 reviewed the progress notes for resident #5324 from May 23, 2014 to June 14, 2014 and found no indication of contraindication for bathing due to a medical condition, or any progress note related to bathing.
The licensee failed to that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)]

WN #11: 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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

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. On June 10, 2014 inspectors #580, #576 and #575 noted that the following required documents were not observed posted in a conspicuous and easily accessible area:
-the home's policy to promote zero tolerance of abuse and neglect of residents;
-an explanation of the duty under section 24 to make mandatory reports;
-a copy of the Local Health Integration Network (LHIN) service agreement;
-an explanation of the measures to be taken in case of fire;
-an explanation of the evacuation procedures;
-copies of the inspection reports from the past two years;
-the most recent minutes of the Residents' council meetings;
-the most recent minutes of the Family Council meetings; and
-an explanation of the protections afforded under section 26.

On June 10, 2014, staff member #300 confirmed to inspector #580 and #576 that copies of public inspection reports for the last 2 years, and a copy of the LHIN service agreement are located in a hanging folder inside the administrative offices. Inspectors #580 and #576 noted that it is not in a conspicuous and easily accessible area.
On June 10 and 12, 2014, inspector #576 and #580 conducted an interview with the ADOC who confirmed that the home's policy to promote the zero tolerance of abuse and neglect of residents is not posted in the home and that evacuation procedures are located in a binder in the home's board room. Inspectors #580 and #576 noted that it is not in a conspicuous and easily accessible area.
On June 16, 2014 inspector #575 noted that the Residents' Council minutes from January 21, 2014 were posted in front of the home's reception desk. The most current Council minutes from May 23, 2014 were not posted.
The licensee did not to ensure that the required information as stated above is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. [s. 79. (1)]

WN #12: 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. On June 13, 2014, inspector #580 found the following expired medication in one of the medication storage rooms:
-calamine lotion expired December 2013
-calamine lotion expired May 2014
-fleet enema expired March 2014
-Latanoprost 0.005% drops expired March 2014
-one unlabelled Novolin Toronto insulin expired November 2013
On June 13, 2014, inspector #580 found the following expired medication in the Magnetewan medication storage room:
-aromatic cascara expired March 2014
-Liquid Potassium 20 mEq expired February 2014
-Liquid Potassium 20 mEq expired April 2013.
The licensee did not ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

2. On June 19, 2014 inspector #575 observed staff member #108 leave the medication cart unattended during lunch dining service. Inspector #575 noted a bottle of Lactulose and an open bottle of Risperidone with a small amount in the bottle left unattended on top of the medication cart. For approximately 2 minutes the cart was unattended. During the time that the cart was unattended, a resident was observed wandering in the hallway near the medication cart. Upon return, the staff member stated to inspector #575 that the Risperidone was left out because it had to be re-ordered and that Lactulose would normally be locked up but it was a busy morning and the staff member did not have time.
The licensee did not ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a) (ii)]

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. On June 13, 2014, inspector #580 observed three separate medication passes by registered staff member #100 to residents #0051 and #0050 without hand washing before or after medication administration.
The licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program. [s. 229. (4)]

2. On June 16, 2014 inspector #575 interviewed the ADOC regarding the resident immunization program. The ADOC confirmed to the inspector that the home does not currently offer tetanus and diptheria to residents. The ADOC stated that if the resident had an injury, the home would send the resident to the Emergency Department and it would be decided there if the resident needed to have the tetanus and diphtheria immunization. The licensee did not ensure that residents are offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Issued on this 4th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDSAY DYRDA (575), MARSHA RIVERS (576), VALA MONESTIMEBELTER (580)
Inspection No. / No de l'inspection :	2014_332575_0008
Log No. / Registre no:	S-000217-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 4, 2014
Licensee / Titulaire de permis :	LAKELAND LONG TERM CARE SERVICES CORPORATION 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4
LTC Home / Foyer de SLD :	LAKELAND LONG TERM CARE SERVICES CORPORATION 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LEN FABIANO

To LAKELAND LONG TERM CARE SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's Mantoux Skin Testing policy, Medication Administration Times policy and the Skin and Wound Care policy are complied with.

Grounds / Motifs :

1. Inspector #576 reviewed the home's Skin and Wound care policy #RSL-DOC-035. The policy states that registered staff are responsible for conducting quarterly skin assessments. The ADOC confirmed that the quarterly skin assessment by registered staff includes a Braden Scale risk assessment and a head to toe skin assessment using the assessment instruments on MEDe-Care. Inspector #576 reviewed the health care records for resident #5339 for a period of approximately 6 months and noted that during this period, a head to toe skin assessment was completed only one time during this period.
The licensee failed to ensure that its Skin and Wound care policy #RSL-DOC-035 was complied with, in that it failed to ensure that a quarterly head to toe skin assessment was completed by a registered staff. (576)

2. Inspector #576 reviewed the home's Skin and Wound Care policy #RSL-DOC-035. The policy states that registered staff are responsible for conducting quarterly skin assessments. The ADOC confirmed that the quarterly skin assessment by registered staff includes a Braden Scale risk assessment and a head to toe skin assessment using the assessment instruments on MEDe-Care. Inspector #576 reviewed the health care records for resident #5335 for a period

of approximately 6 months and noted that during this period, a head to toe assessment was not completed and the Braden Scale risk assessment was completed only one time during this period.
The licensee failed to ensure that its Skin and Wound Care policy #RSL-DOC-035 was complied with, in that it failed to ensure that a quarterly head to toe skin assessment and Braden Scale risk assessment was completed by a registered staff. (576)

3. Inspector #576 reviewed the home's Skin and Wound Care policy #RSL-DOC-035. The policy states that registered staff are responsible for conducting quarterly skin assessments. The ADOC confirmed with inspector #576 that the quarterly skin assessment completed by registered staff includes a Braden Scale risk assessment and a head to toe skin assessment.
Inspector #576 reviewed the health care records for resident #5301 and was unable to locate a head to toe skin assessment completed in the past 6 months.
Inspector #576 confirmed with registered staff member #101 and the ADOC that a head to toe skin assessment was not completed for resident #5301 in the past 6 months.
The licensee failed to ensure that its Skin and Wound Care policy #RSL-DOC-035 was complied with, in that it failed to ensure that a quarterly head to toe skin assessment was completed by a registered staff. (576)

4. On June 17, 2014 inspector #580 reviewed the home's General Policy – Medication Administration Times effective January 2010 which states that no person except a Physician, Dentist, RN or RPN, shall administer a drug to a resident.
On June 13, 2014 inspector #580 interviewed staff member #100 regarding the administration of topical medication. Staff member #100 advised inspector #580 that non-registered staff apply medication on residents' skin. The staff member further indicated that registered staff show the PSWs how to apply the creams, how to report back on skin changes, how to document and ensure that the PSWs report back to the registered staff after applying the medicated creams.
On June 17, 2014 staff members #101 and #102 confirmed to inspector #580 that PSWs are given creams to apply to residents. On June 17, 2014 staff members #200, #201 and #202 confirmed to inspector #580 that non-registered staff members apply medicated creams to residents as per instructions from the registered staff.
The licensee did not ensure that its policy for Medication Administration Times effective January 2010, was complied with, in that it failed to ensure that no

person except a Physician, Dentist, RN or RPN, administers a drug to a resident. (580)

5. On June 16, 2014 inspector #575 reviewed the home's Mantoux Skin Testing policy dated July 2012. The policy indicated that all residents admitted to the home will have a 2-step TB skin test initiated within 14 days of admission. The policy further indicated that the 1st step should be completed within the first week of admission and read 48 to 72 hours after test is administered. The 2nd step should commence 7 to 28 days after the first step was initiated.
On June 16, 2014 inspector #575 reviewed the immunization records for resident's #5295, #5357, and #5359.
Resident #5295 was admitted to the home in 2005. Records indicate that resident #5295's 1st step TB test was not initiated until 2006, more than 14 days after admission. Further, the immunization record does not indicate what date the test was read.
Resident #5357 was admitted to the home in 2012. Records indicate that resident #5357's 1st step TB test was initiated in 2012 however the immunization record does not indicate what date the test was read. The 2nd step was initiated and read on the same day in 2013.
Resident #5359 was admitted to the home in 2012. Records indicate that resident #5359's 1st step TB test was initiated and read on the same day in 2012. Further, the 2nd step was initiated and read on the same day in 2012 and more than 7 to 28 days after the first step was initiated.
The licensee did not ensure that its policy for Mantoux Skin Testing dated July 2012, was complied with, in that it failed to ensure that all residents admitted to the home had a 2-step TB skin test initiated within 14 days of admission and that test was initiated and read within the specified timeframes. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that all staff receive training and annual re-training of infection prevention and control.

Grounds / Motifs :

1. In June 19, 2014 inspector #575 completed an audit of the Infection Prevention and Control staff training records for 2013 and 2014. The training records were compared to the number of current staff as per the ADOC. Training records for hand hygiene, modes of infection transmission, cleaning and disinfection practices and use of personal protective equipment were reviewed. It was determined that only 12/149 staff or 24.5% of staff completed hand hygiene, 54/149 staff or 36.2% of staff completed modes of transmission and personal protective equipment, and 24/149 staff or 16.1% of staff completed cleaning and disinfection. Additionally, only 72/149 staff or 48.3% of staff completed online infection control training and 12/149 staff or 8.1% of staff completed online training for personal protective equipment.
The licensee did not ensure that all staff at the home receive training and retraining in infection prevention and control as required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act including hand hygiene, modes of infection transmission, cleaning and disinfection practices, and use of personal protective equipment. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure that all staff who provide direct care to residents receive annual training on skin and wound care and how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

Grounds / Motifs :

1. Inspector #576 completed an audit of the Restraints Program staff training records for 2013 and 2014. The training records were compared to the current staff list provided by the home. Training for direct care staff including RNs, RPNs, and PSWs was reviewed. Inspector #576 noted that training on minimizing of restraining of residents during this period included the following:
-in 2013, only 1/7 RNs, 7/24 RPNs, and 14/81 PSWs completed the online surge learning course for "restraint use";
-in 2014, only 0/7 RNs, 6/24 RPNs, and 0/81 PSWs completed the online surge learning course for "minimizing of restraints";
-in 2014, only 0/7 RNs, 3/24 RPNs, and 19/81 PSWs completed the online surge learning course for "reducing restraints"; and
-in 2014, only 0/7 RNs, 0/24 RPNs, and 19/81 PSWs completed the online surge learning course for "restraint use".

The licensee did not ensure that all staff who provide direct care to residents receive training and re-training annually on minimizing the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. (576)

2. Inspector #576 completed an audit of the Skin and Wound Care Program staff training records for 2013 and 2014. The training records were compared to the current staff list provided by the home. Training for direct care staff including RNs, RPNs, and PSWs was reviewed. Inspector #576 noted that training on skin and wound care during this period included the following:
-on April 22, 2013, only 1/7 RNs, 0/24 RPNs, and 0/81 PSWs attended the RNAO Webcast "Mananagment of Stage 1 to Stage IV Pressure Ulcers";
-on November 6, 2013, only 0/7 RNs, 2/24 RPNs, and 18/81 PSWs attended training on "Footcare";
-on March 31, 2014 only 5/7 RNs, 10/24 RPNs, and 18/81 PSWs completed a questionnaire "Catch the Wave"
-on January 14, 2014, only 1/7 RNs, 2/24 RPNs, and 0/81 PSWs attended an in-house training on "Chronic Wounds in LTC"; and
-on April 16, 2014, only 0/7 RNs, 0/24 RPNs, and 17/81 PSWs completed the online surge learning module on "Prevention of Pressure Ulcer Training".
The ADOC confirmed training on various skin and wound care topics was poorly attended by direct care staff and that annual retraining on the home's skin and wound care program was not provided by the home to direct care staff.
The licensee did not ensure that all staff who provide direct care to residents receive training and re-training annually on skin and wound care. (576)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

Service Area Office /
Bureau régional de services : Sudbury Service Area Office