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

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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
Nov 25, 2015	2015_360111_0019	O-002644-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

HILLSDALE TERRACES
600 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

LYNDA BROWN (111), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14-18 and 21-22, 2015

The following intakes were completed concurrently during this inspection:O-002066-15 regarding a complaint and critical incident report related to a fall with injury, O-002152-15 regarding a complaint related to a fall with injury and care concerns, O-002466-15 regarding a follow-up to an order related to falls, and O-002203-15 regarding a follow-up to an order related to late reporting of abuse.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Resident Care Coordinators(RCC), Infection Prevention and Control Practitioner (IPACP), Director of Environmental Services, Supervisor of Environmental Services, Occupational Therapist (OT), Physiotherapist (PT), RAI Coordinator, Housekeeping Aide(HSKA), Pharmacy Consultant, President of Resident and Family Council, Registered Nurse(s), Registered Practical Nurse (s),Personal Support Worker(s), Dietary Aide(s), Activity Manager, Activity Staff, Maintenance worker(s), Residents and Families.
During the course of this inspection, dining observations were made, medication administration observation and, observation of resident and non-resident areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2015_365194_0009	554
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2015_270531_0011	570

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

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

Specifically failed to comply with the following:

s. 6. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (2), by not ensuring the plan of care is based on an assessment of the resident and resident's needs and preferences.

During the dates of September 14, through to September 16, 2015, 7 resident rooms were observed to have plastic child-proof locks on wardrobe and drawers; these resident rooms were located on a specified unit.

12 Resident rooms were also noted (September 18, 2015) to have closet doors (and or drawers) locked using a plastic child-proof lock.

Interviewed of Resident #001 and Resident #006 on on a specified date,both indicated not knowing why their closets and drawers in their rooms were locked and were unable to unfasten the child-proof plastic lock to access their clothing or personal belongings when asked by the inspector.

Interview of S#107 and S#104 on a specified date, indicated that the child-proof locks were placed on all resident closets and drawers in the home area due to responsive behaviours of residents. Both staff indicated that locking closets and drawers allow only staff (and or families) to access resident's belongings and this keeps residents personal items from going missing. S#104 and S#107 indicated residents are unable to remove

the plastic locks, due to residents being cognitively impaired.

Interview of Resident Care Coordinator(RCC) indicated the child-proof plastic locks (and or key locks) were initiated a few years ago, due to increasing family complaints about missing resident personal items. The RCC indicated that the locks are "automatically" applied by the home to resident wardrobes and or drawers on the specified unit. RCC indicated not knowing if an assessment of the resident's needs and or preferences was completed prior to the application of the locks.

S#104, indicated that there is no assessment on file specific to the use of the plastic-locks for individual residents nor is the use of such noted in resident's plan of care. S#104 indicated that the plastic locks are automatically placed on the closets and drawers of residents residing the secured unit.

A review of Resident #001 and Resident #006's plan of care, had no documented evidence of an assessment of resident's needs and or preferences for the use of plastic locks being applied to their wardrobe and/or drawers.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to notifying the SDM with changes in condition.

Related to Log #002066-15:

Resident #050 sustained a fall on a specified date and was sent to hospital for further assessment. A telephone interview with SDM for Resident #050 indicated that while at the hospital with the resident, the SDM noted an injury to a specified area that the SDM was not notified of.

Review of clinical records (electronic and paper) for Resident #050 indicated a note that directs staff to call the SDM at any time 24 hours a day if there is an injury.

Review of Treatment Administration Record (TAR) for a two month period for Resident #050, indicated the resident had sustained an injury to a specified area.The TAR indicated that treatment was provided on three specified dates in the month before the hospitalization. Review of progress notes for Resident #050 for the same time period had no documented evidence related to the injury identified in the TAR, and no evidence the SDM was notified.

Interview with S#124 indicated alterations in skin are documented on both the progress notes and TARs, and SDM notifications are recorded on progress notes. S#124 indicated Resident #050's injury was recorded on TAR during a two month period and should have been recorded on progress notes, as well as the SDM notification. S#124 confirmed there was no progress note to indicate that the SDM of Resident #050 was notified of the injury.

3. The licensee has failed to ensure the resident was reassessed, and the plan of care was revised, because the care set out in the plan of care was not effective in reducing injuries to Resident #049's skin and that different approaches were considered in the revision of the plan of care.

Related to log #002125-15:

Review of the health care record for Resident #049 identified the resident was a high risk for injuries to skin.

Observation of Resident #049 indicated the resident was in a mobility aide and had minimal use of one side due to diagnosis. Padding was noted on bilateral bed rails and on the ceiling lift bar. There was also protective floor mats noted beside the bed.

Review of the current care plan for Resident #049 indicated the resident is totally dependent with transfers and bed mobility related to diagnosis and cognitive impairment, and had no use of one side. The resident requires two staff assistance with a mechanical lift (using the ceiling lift and full sling), requires two staff assistance to turn or reposition the resident in bed or chair, and use of partial side rails up when in bed. Under skin integrity indicated presence of alteration in skin integrity due to: physical changes in the skin, contributing diagnosis, and responsive behaviours.Interventions included: documenting any skin redness/breaks/rashes, application of barrier cream daily to specified areas, keep nails cut, staff avoid wearing sharp objects, and physician ordered medication to relieve triggers to responsive behaviours.

Review of the progress notes (over a five month period) for Resident #049 indicated the resident sustained 4 skin injuries to specified areas and 2 incidents of bruising to specified area. The first two injuries were received while staff were providing personal care. After the third injury (of unknown cause) the family requested protective measures to the resident's room to reduce the possible injury to the resident's skin.

Three days later, daily skin assessments were initiated. Approximately 15 days later, interventions requested by the family were implemented to reduce the possibility of skin injury to the resident.
Approximately 7 days later, the resident sustained skin injury while staff were transferring the resident. Approximately two months later, the resident sustained a skin injury to a specified area of unknown cause. The following month, the family was visiting the resident and noted an injury to a specified area and reported the injury to staff. Staff indicated the injury was of unknown etiology but could have occurred due to triggers resulting in resident responsive behaviours.

Interview of S(#111) indicated Resident #049 is totally dependent on staff for all personal care and is unable to move in bed or chair without 2 staff assistance. Indicated the resident requires ceiling mechanical lift for all transfers with use of two staff, and has minimal use of one side, and protective measures were implemented at the request of the family for resident safety. The staff member also indicated the resident was prone to skin injuries and has history of skin injuries.

Interview of S#117 indicated Resident #049 sometimes has triggers that result in responsive behaviours by the resident, which results in skin injury to specified area and thought that was how the injury occurred on a specified date. S#117 also indicated that protective measures to the residents room were implemented as a result of that injury.

The plan of care was not revised when the resident sustained 3 skin injuries, and different approaches were not considered until the family requested additional interventions (protective measures to room environment). Daily skin assessments was the only other intervention considered (approximately a week later) and no other interventions were considered despite the resident continuing to sustain skin injuries that were occurring while the resident was receiving personal care, to reduce or minimizing the risk of skin injury.

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 the written plan of care for Resident #001 and #006 as set out in the plan, is based on the assessment of the resident, and the needs and preferences of those residents; to ensure the care as set out in the plan for Resident # 050 is provided to the resident as specified in the plan; and to ensure that if the plan of care for Resident #049 is being revised because the plan has not been effective related to skin injuries, that different approaches are considered in the revision, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with related to Falls Prevention and Management.

Under O. Reg. 79/10, s.48(1)1 every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury

Related to Resident #20:

Review of the licensee's Fall Prevention & Management Program policy # INTERD-03-08 -01 revised in April 2014 directs:

There is a clear process for immediate assessment and intervention when a resident has fallen:
- The home will use a comprehensive post fall assessment designed to examine in depth risk areas to falls, eg. drug regimes, restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Review of the clinical health record for Resident #20 indicates that the resident sustained 4 falls over a two month period resulting in injury and/or pain to specified areas. A post fall assessment was completed for only one of the falls.

S#105 and S#103 were unable to locate any records to indicate that the post fall assessment form was completed for the 3 falls.

Interview with RCC #119 who is in charge of the falls prevention program at the home indicated the expectation is that post fall assessment form is to be completed for each fall.

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with related to medication storage.

On a specified date and time,a physician prescribed treatment cream for Resident #040 was found on top of the resident's bedside table.

Interview of S#100 indicated that prescribed treatment creams should only be secured at the resident's bedside, if there is a physician order in place indicating that it can be at the bedside. S#100 then removed the treatment cream from the bedside.

Review of the physician's order for Resident #040 had no documented evidence that the prescribed treatment cream was to be at the resident's bedside.

Review of Treatment Administration Record (TAR) for a specified month, indicated “in room” under the prescribed treatment cream, despite no physician order.

Review of the home's policy by Medical Pharmacy "Medication Storage" 3-4 (dated January 2014) indicated "all medications are safely stored and supervised in accordance with applicable legislation".

Interview of the Pharmacy consultant indicated the policy "Medication Storage" applied to both internal and external medications that are to be stored safely.

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to self administration of medications.

Under O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

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

Under O. Reg. 79/10, s. 131 (6), where a resident of the home is permitted to administer a drug to himself under subsection (5), the licensee shall ensure there are written policies to ensure the residents who do so understand, the use of the drug, the need for the drug, the need for monitoring and documentation of the use of the drug, and the necessity for safe-keeping of the drug by the resident, where the resident is to keep the drug on his person or in his room.

The home's policy, "Self-Administration of Medications" (Medical Pharmacy #5-5) directs that self-administration of medications by a resident is permitted when specifically ordered by the physician who, with input from the nursing team, determines that the resident is capable of self-administering his/her own medications. These medications are stored in a secure area, inaccessible to other residents.

Procedures indicated in this policy include, but not limited to:
- Prescriber and nursing team assesses resident for their capacity to self-administer their own medication and complete the "self-administration assessment form" File form with medication administration record (MAR);
- Prescriber writes the medication order including in the directions "may self-administer";

- Prescriber and or nurse counsels the resident regarding the name of the medication, strength, dosage, frequency, indication(s), method of use, adverse effects, safe storage, possible adverse effects and reordering procedure. The resident must understand the need for self-monitoring and documentation of the drug. Prescriber or nurse document counselling of all of the above in the progress notes of facility specific documentation;
- Resident signs “Resident Self-Administration of Medication Agreement”. The form is filed in resident’s chart;
- Monitor the resident’s ability to self-administer medications and notify physician of any change in resident’s condition;
- Complete the “self-administration assessment form” quarterly or with any change in resident’s status;
- Document in the resident’s care plan that they have been identified as capable of self-administering medications;
- Monitor resident’s compliance in the use of self-administration of medications; if missed doses are noted further counselling or the medication removed;
- Document in the progress notes weekly that monitoring has been done and the extent to which resident has been compliant with self-administration. Report any concerns to the physician
- Resident can monitor and document the use of the drug

Specified medications were observed sitting on a window ledge in Resident #027’s room over a five day period unsecured. The door to resident`s room was open and co-residents were observed in the hallway and or wandering past resident’s room.

A review of the clinical health record (physician’s orders, physician medication review, and medication administration record), for Resident #027 indicated the the resident was able to "self-administer" the observed medications in the resident's room.
- A Self-Administration Assessment Form (dated five years ago) indicates: “resident may self-administer medications, including topical medications”. The form does not specify which medications, is signed by the resident and a registered nurse, and the area where physician is to sign is blank. There was no other self-administration assessment form on file for this resident.
- Progress notes and medication administration records, reviewed for a three month period, had no documented evidence that self-administration of medications by Resident #027 was being monitored by Registered Nursing staff.
- The current care plan does not make reference to Resident #027 self-administering medications.

Resident #027 indicated, during an interview that he/she self-administers specified medications and indicated the frequency. The resident indicated rarely uses one of the medications but neither medications were being administered as prescribed. Resident #027 indicated he/she does not document the self-administration of either medication, nor does staff ask if they have been administered and will ask the Registered Nursing staff for replacement of the medication as needed.

S#106, indicated the Registered Nursing staff do not monitor Resident #027 to determine if the resident is taking the medication as prescribed. S#106 indicated they assume resident takes the medications as per physician's orders and comes to registered nursing staff when needs more of the medication. S#106 indicated no awareness of the "self-administration assessment form" having been completed and commented "that would be up to resident's physician to complete the form and assess resident's ability to self-administer medications, not registered nursing staff".

Both S#106 and S#120 indicated they were not familiar with the home's policy on Self-Administration of Medications.

The licensee failed to comply with the home's policy, Self-Administration of Medications, as evidenced by the following:
- not monitoring the resident's ability to self-administer medications and the resident only taking the medication in the morning versus as twice daily as ordered;
- not completing the "self-administration assessment form" quarterly- last completed June 07, 2011;
- not document in the resident's care plan that they have been identified as capable of self-administering medications; no evidence in care plan of "self-administration";
- not monitoring resident's compliance in the use of self-administration of medications; if missed doses are noted further counseling or the medication removed; RPN#106 not aware that resident only taking eye drops daily;
- not documenting in the progress notes weekly that monitoring has been done and the extent to which resident has been compliant with self-administration. Report any concerns to the physician. No evidence in progress notes (over a three month period) of weekly monitoring by registered nursing staff;
- there is no documented evidence that Resident #27 had documented taking of the medications;
- not ensuring medications are secured and inaccessible to other residents as the two medications were observed accessible in the resident's room.

Resident Care Coordinator (RCC) indicated it is an expectation that the home's policies, specifically Self-Administration of Medications, are to be followed. RCC indicated medications, which includes topical medications are to be securely stored either in a medication room, medication cart or in a locked cupboard in a resident's room.

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 the home's policy on Falls Prevention and Management, safe storage of medications, and self-administration of medications, to be implemented voluntarily.

WN #3: 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 failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

A lingering offensive odour was noted over a five day period, in 5 resident washrooms, (two that are shared), and one communal washroom. The lingering offensive odour in all but one, strongly resembled urine.

Housekeeping Aide (HSKA) #112, indicated that the home uses 'Good Sense Spray' to aide with reducing odours; HSKA #112 indicated all resident rooms and washrooms are cleaned and washed daily, and if an odour is detected, housekeeping staff can spray 'Good Sense' on the privacy curtains to decrease room odours. HSKA #112 indicated that the only room on the unit that occasionally has an offensive and lingering odour was one of the identified resident rooms and was due to the resident having a bowel issue. The staff member was unaware of lingering offensive odours in the remaining resident bathrooms or communal washroom.

Interview of the Director of Environmental Services and Supervisor of Environmental Services indicated they were not being told by staff of an odour issue in resident washrooms or communal washrooms located on a specified unit. The Supervisor indicated that if he would have known, 'Clorox Odour Eliminator' would have been provided to housekeeping staff to use to assist in decreasing the lingering offensive odours.

The lingering offensive odour remained present in all identified rooms.

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 procedures for lingering offensive odours are developed and implemented to address them, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure drugs are stored in an area or a medication cart, that is secure and locked.

On a specified date and time, a prescribed treatment cream was observed on Resident #043's beside table. Resident #43's door was open and co-resident's were noted to be in the hallways surrounding Resident #043's room.

S#106 indicated that the observed treatment cream is considered a medication and is self-administered by Resident #43; there is no order for self-administration of this medication for this resident. S#106 indicated resident's rooms are not locked and are not considered to be a 'secured location'.

The home's policy, Medication Administration Program (#INTERD-03-03-19) directs that every home shall ensure that drugs, which include topical medications, are to be secure and locked.

Resident Care Coordinator indicated medications are to be securely stored in the medication cart, medication room and or in a locked cupboard in an individual resident's room. RCC indicated the treatment cream located at Resident #43's bedside would not be considered secure.

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 all medications are kept secured and locked, to be implemented voluntarily.

WN #5: 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 failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber and in consultation with the resident.

On a specified date and time, a prescribed treatment cream was observed on Resident #043's beside table.

Interview of S#106 indicated that Resident #043 self-administer's the prescribed treatment cream to a specified area, is considered a medication, and the resident only applies the medication as needed.

A review of the Physician's orders for a three month period indicated Resident #043 was prescribed the treatment cream to be applied daily to a specified area. There was no documented evidence that Resident #043 was approved by the physician to self-administer the treatment cream.

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 resident's do not self-administer medications unless approved by the prescriber and in consultation with the resident, to be implemented voluntarily.

WN #6: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure there is a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

The Provincial Infectious Disease Advisory Committee (PIDAC) directs that alcohol-based hand rub is the preferred method for decontaminating hands. Using alcohol-based hand rub is better than washing hands (even with an antibacterial soap) when hands are not visibly soiled. For maximum compliance and use, health care providers should perform hand hygiene at the appropriate moment of care. ABHR should be located at point-of-care, i.e., the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. Point-of-care products should be accessible without leaving the client/patient/resident. Installing ABHR dispensers at the point-of-care improves adherence to hand hygiene.

The "Just Clean Your Hands" hand hygiene program directs that Alcohol-Based Hand Rub (ABHR) dispensers are to be placed "within an arm's reach of where care is

provided to residents". The Just Clean Your Hands Program identifies that "providing ABHR at the point of care makes it easier for staff to clean their hands the right way at the right time".

During observations September 14 to September 15, 2015, 8 resident rooms on a specified unit were observed to have no point-of-care hand hygiene agents inside the resident rooms. Further observations on September 17, 2015 by the inspector, indicated that all resident rooms located on a specified unit do not have point of care hand hygiene agents.

S#107 and S#109 indicated "they do not carry a personal supply of alcohol based hand rub (ABHR), nor does the home supply staff one to carry". Both staff indicated that they had to remove their gloves in the resident's rooms and walk down the hallway to cleanse their hands as they are the closet ABHR dispensers available.

Infection Prevention and Control Practitioner (IPACP) indicated that the home follows "Just Clean Your Hands" hand hygiene program and PDIAC best practice guidelines for Hand Hygiene. IPACP indicated that "having hand hygiene agents accessible at point-of-care is best practice when following the "Just Clean Your Hands" hand hygiene program". IPACP indicated that direct care staff, on the specified unit do not carry personal bottles of ABHR, as part of the hand hygiene program at the LTC home.

Hand hygiene agents are not accessible at the point-of-care, on a specified unit.

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 access to point-of-care hand hygiene agents are available in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident's shower has at least two easily accessible grab bars, with one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

On September 14 and 22, 2015, an observation of a specified unit Spa Room did not have an accessible grab bar located on the same wall as the faucet in the shower stall.

Interview of the Director of Environmental Services and the Supervisor of Environmental Services indicated they were not aware that the Rose Garden spa room did not have a grab bar on the faucet side of the wall.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to Resident #046 demonstrated responsive behaviours, where possible.

The resident was admitted to the home with diagnosis including cognitive impairment. RAI MDS completed in a specified month indicated the resident exhibited increased responsive behaviors on a daily basis that is not easily altered.

Interview with S#113 indicated Resident #046 demonstrates responsive behaviours while staff attempt to provide personal care, they usually have to re-approach the resident several times before care is accepted. The staff member further explained that the responsive behaviour exhibited by the resident fluctuates on a daily basis.

Interview with S#118, indicated Resident #046 speaks a second language and at times will begin speaking in the second language to staff. The staff member explained the responsive behaviours increase when the resident is trying to communicate with staff. The staff member indicated the care plan for Resident #046 should include strategies to respond to the resident's responsive behaviours.

The care plan does not indicate the resident demonstrates the responsive behaviours or strategies staff should use to respond to these behaviours.

Issued on this 26th day of November, 2015

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

Original report signed by the inspector.