Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2014	2014_109153_0003	T-007-14	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

BLOOMINGTON COVE
13621 Ninth Line, Stouffville, ON, L4A-7X3

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

LYNN PARSONS (153), BARBARA PARISOTTO (558), ERIC TANG (529), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 2014.

During the course of the inspection, the inspector(s) spoke with executive director(ED), Director of Care(DOC), director of dietary services(DDS), director of resident and family services(DRFS), physician, nurse practitioner(NP), assistant director of care(ADOC), physiotherapist(PT), registered dietitian(RD), resident assessment instrument-minimum data set(RAI MDS) coordinator, restorative care coordinator, registered nurse(RN), registered practical nurses(RPN), personal support workers(PSW), recreation therapist(RT), cook, dietary aide(DA), handyman, housekeeper, residents and families.

During the course of the inspection, the inspector(s) reviewed clinical health records, Resident and Family Council minutes, menus, staff training records, staffing schedules, preventative maintenance program, cleaning schedules, immunization records, drug destruction records, home policies and procedures related to nutrition, responsive behaviours, abuse, medication system, personal care, infection control, fall prevention, skin and wound;
completed observations related to medication administration, resident to staff interactions, resident to resident interactions, provision of care, dining and snack service;
completed a tour throughout the home.

During this inspection the following complaint logs were inspected: T-386-13, T-477-14.
During this inspection the following critical incident logs were inspected: T-145-13, T-247-13.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.
a) The plan of care for resident #5095 under the hygiene section related to nail care states check nails, and clean twice a day (feet and hands) or more often as necessary.
Observations completed on the following dates and times revealed the resident's fingernails were long, jagged and dirty:
- April 2, 2014, at 2:00p.m.
- April 8, 2014, at 11:00a.m.
- April 9, 2014, at 2:00p.m.
- April 10,2014, at 8:15a.m.
Interviews with staff confirmed nail care is to be provided on bath/shower days.
When interviewed the RPN confirmed that resident #5095 required nail care to be completed.
An observation completed on April 11, 2014, at 8:10a.m. revealed the resident's fingernails to be trimmed and clean.

b) During breakfast on April 7 and 8, 2014, it was observed that resident #0001 did not receive the nutritional supplement labeled with the resident's name. A review of the plan of care identified the resident is to receive a nutritional supplement at breakfast,

lunch and dinner. During an interview with a staff member it was confirmed that the nutritional supplement was not given as ordered. [s. 6. (7)]

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

a) On review of resident #0013's behavioural monitoring tool the following dates and times were noted not to be documented from February 1 - 18, 2013:
- February 2 - 7:00a.m.
- February 3 - 6:30a.m., 7:00a.m.
- February 6 - 1:30p.m. to 3:00p.m.
- February 8 - 2:45p.m., 3:00p.m., 11:15p.m., 11:30p.m., 11:45p.m.
- February 9 - midnight to 6:45a.m., 7:00a.m. to 10:45a.m.
- February 10 - 5:15a.m. to 6:45a.m.
- February 12 - 12:00p.m. to 3:00p.m.
- February 14 - 12:15p.m. to 3:00p.m.
- February 18 - 6:15a.m. to 6:45a.m.,10:45a.m. to 3:00p.m.

Interviews with nursing staff and the DOC confirmed the behavioural monitoring tool was not documented every 30 minutes as required.

b) On review of resident #0014's behavioural monitoring tool the following dates and times were noted not to be documented from May 12 - 17, 2013:
- May 12 - day shift, 11:15p.m. to 11:45p.m.
- May 13 - 2:30a.m. to 6:45a.m.
- May 14 - day and evening shift
- May 15 - day, evening and night shift
- May 16 - day shift, 3:15p.m. to 7:00p.m.
- May 17 - 2:15p.m. to 7:00p.m.
- May 19 - 7:00a.m. to 7:45a.m., 8:15a.m., 10:15a.m., 2:15p.m. to 3:00p.m.
- May 20 - 7:15a.m to 3:00p.m.
- May 21 - 6:45a.m., 2:15p.m. to 4:45p.m.
- May 22 - 11:00p.m.

Interviews with nursing staff and the DOC confirmed the behavioural monitoring tool was not documented every 30 minutes as required.

c) The nutritional plan of care for resident #5046 directs staff to provide a nutritional

supplement three times daily at breakfast, afternoon snack, and dinner. A review of the food and fluid flow sheet for March 2014, failed to identify documentation for the nutritional supplement at breakfast and dinner. An interview with the DOC confirmed that the provision of the care was not documented.

d) The shower list indicates resident #5095 is scheduled to receive a shower and nail care twice a week.
A review of the observation record for resident #5095 for March and April 2014, failed to reveal documentation as to whether nail care had been provided for the following dates:
March 4, 6, 13, 20, 25, 27 and April 3, 2014.
A review of the observation record for resident #5095 for March 2014, failed to reveal documentation to indicate whether the resident received a shower as scheduled on March 13, 20, 25, 27 and April 3, 2014.
A review of the progress notes for the above dates failed to reveal documentation to indicate reasons for the shower or nail care not being provided.
When interviewed the registered staff confirmed that documentation should have been completed on the scheduled shower days related to bathing and nail care. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

a) A review of resident #5075's plan of care indicated the staff were to use laminated cards containing sentences in the resident's language and pictures as tools when communicating with the resident.
Interviews with the nursing staff indicated this intervention had not been in place for an extended period of time.
The above intervention remains in the plan of care but is not currently in place when communicating with resident #5075.
An interview with the DOC confirmed that the resident's plan of care is to be revised when an intervention is no longer necessary in order to support resident care needs.

b) Record review indicates that resident #0013 has an alarm installed that would sound when another resident is in the room. However, the intervention had not been entered into the resident's written plan of care that covered March and May 2013.
Interviews with two registered nursing staff and the DOC have confirmed that the intervention had not been inputted into resident #0013's March and May 2013 written

plan of care.

c) The first RAI MDS quarterly assessment for resident #5095 indicated the resident was moderately cognitively impaired, easily distracted and experienced periods of lethargy. The RAI MDS assessment related to communication indicated resident #5095 hears adequately without the use of assistive aides for hearing. The mode of communication involves clear speech with the use of signs/gestures and sounds. Resident #5095 usually understands and is sometimes understood.

The next RAI MDS quarterly assessment indicated the resident was severely cognitively impaired and never/rarely made decisions.
The RAI MDS assessment related to communication indicated resident #5095 hears adequately without the use of assistive aides for hearing. The resident does not have speech, sometimes understands and rarely or never is understood.
The assessment indicated there had been no change in the last ninety days.
A review of the outcome scales revealed a cognitive performance (CPS) score of 5 and a communication (COMM) score of 5 which indicated a deterioration in these areas from the previous quarter outcome scores which were CPS 4 and COMM 3.

A review of the plan of care for resident #5095 revealed the following information related to communication:
Focus
- decreased /lack of hearing related to language barrier and cognitive impairment

Interventions
- get resident's attention before beginning to speak to resident
- move resident to low-noise place or remove as much background noise as possible before speaking with resident
- use short direct phrases when talking with resident.

When resident #5095's cognitive and communication abilities deteriorated as identified with the completion of the quarterly assessments, the plan of care was not revised to reflect the resident's change in needs.
The DOC confirmed when interviewed that the resident's plan of care was not revised when the quarterly assessment indicated a change in resident #5095's cognitive and communication needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that;
- the care set out in the plan of care is provided to the resident as specified in the plan
- the provision of care set out in the plan of care is documented
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with locks to restrict unsupervised access to those areas by residents.
On April 2, 2014, at 11:13a.m. in the patio lounge, the inspector observed an exterior door on the second floor cottage home area which led to a secure outside area, to have a block of wood affixed to the door in such a way the crash bar was unable to be pushed to open the door.
There was no lock installed on the exterior door.
When interviewed the ED confirmed there was no lock in place except for the block of wood. [s. 9. (1) 1.1.]

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 all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with locks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment is kept clean and sanitary.
a) On April 2, 2014, at 2:46p.m. it was observed that resident #5032's wheelchair was covered with food debris.
On April 4, 2014, at 10:18a.m. it was noted that the wheelchair seat cushion and the right foot pedal strap were soiled.

On April 7, 2014, at 1:59p.m. it was noted there were stains on the seat cushion at the back and on the right corner.
On April 8, 2014, at 8:45a.m. stains were noted on the seat cushion and both foot pedal straps.
A review of the wheelchair cleaning record for resident #5032 indicated the wheelchair was cleaned on March 31 and April 7, 2014.
When the above observations were shown to the nursing staff and the DOC it was confirmed that resident #5032's wheelchair was not clean.

b) On April 1, 2014, at 4:02p.m. it was observed that resident #5056's wheelchair was soiled and covered with food particles.
On April 4, 2014, at 10:05a.m. it was observed that resident #5056's wheelchair contained food-like debris at the base of the wheelchair cushion, the foot pedals and pedal straps were soiled and there was a dried yellow spot noted at the side of the seat cushion.
On April 7, 2014, at 11:25a.m. the wheelchair was noted to have food-like debris on the wheelchair seat and seat cushion.
On April 8, 2014, at 8:35a.m. the wheelchair was observed to have dried stains on the wheelchair seat and seat cushion.
A review of the wheelchair cleaning record for resident #5056 indicated the wheelchair was cleaned on March 27 and April 1, 2014.
When the above observations were shown to the nursing staff and the DOC it was confirmed that resident #5056's wheelchair was not clean. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home and furnishings are maintained in a safe condition and in a good state of repair.
a) The following observations were completed on April 2, 2014, at 11:13a.m.
second floor - cottage house:
- shower room - chipped ceramic wall tile
- paper debris stuck to wooden table in patio lounge
- radiator open and exposed in patio lounge
- resident room #241 - radiator section cover missing and pipe exposed
- resident room #238 - floor in bathroom lifting in the corner of the bathroom and under the radiator
- resident room #238 - hole in bathroom door
- resident room #237 - wall damage in bathroom wall near the floor
- resident room #237 - hole in bathroom door

- holes in drywall near stairwell A at the end of the hallway
- furniture legs were noted to be scuffed in the common areas.

b) The following observations were completed on April 2, 2014, at 8:45a.m.
third floor - country house:
- ceramic wall tile chipped in shower and tub rooms
- resident room #321 - scuff marks on wall at head of bed and wall chipped in bathroom
- furniture legs were noted to be scuffed in the common areas.

A review of the maintenance log binder failed to identify the above areas for repair.
Interview with the handyman confirmed the areas required repair.
The home initiated repairs to some of the above areas over the week-end of April 5 and 6, 2014. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident-staff communication and response system can be easily accessed and used by residents, staff and visitors at all times. The following residents were observed to have a resident-staff communication and response system that was inoperable:
a) On April 2, 2014, at 12:10p.m.and 12:44p.m. in resident room #241 on cottage house, the call bells at the bed stations did not activate when pulled resulting in no audible sound or light activated outside the door in the hallway for beds 1, 2 and 4. When interviewed a PSW confirmed 3 out of the 4 resident-staff communication and response system were unable to be activated. The PSW indicated the handyman would be notified.
The ED was made aware and the situation was resolved.

b) On April 4, 2014, at 2:40p.m. the inspector observed the call bell cord in the bathroom of resident room #238 on cottage house to be caught in the hooks installed on the wall and the end of the cord was tied to the grab bar preventing the cord from being pulled to activate the call bell.
A PSW was asked to demonstrate how a resident would activate the call bell in the bathroom. She pulled on the call bell cord but the call station would not activate. She then commented that the end of the call bell had been tied to the grab bar which was preventing the call bell from being activated.
When she untied the call bell from the grab bar she had great difficulty in activating the call bell because the call bell cord was caught tightly in the hooks on the wall which would not allow the cord to be pulled.

On April 4, 2014, at 2:45p.m. the inspector visited resident room #232 bathroom and observed the call bell cord to be located on the opposite wall from the toilet. In order to activate the call bell cord the resident would have to lean forward from the toilet to reach the call bell cord which was not accessible.
The situation was reviewed with the ED who confirmed a potential risk and suggested an intervention to resolve the situation.

c) On April 8, 2014, at 8:15a.m.and at 11:00a.m., the inspector observed resident #5036 lying in his/her bed and the call bell was lying on the floor beside the bed. The resident is able to use the call bell but it was not accessible for use by the resident.
The location of the call bell was brought to the attention of the PSW who picked it up and tied the call bell cord to the bed rail making it accessible for the resident to use. [s. 17. (1) (a)]

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 resident-staff communication and response system can be accessed and used by residents,staff and visitors at all times, to be implemented voluntarily.

WN #5: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff have received annual retraining on infection prevention and control.
A review of the staff training records revealed 2 out of 102 staff did not receive training in infection prevention and control in 2013.
The staff who did not receive training in 2013 involved direct care staff who continue to work at the home.
When interviewed the ED and DOC confirmed that the two staff members did not receive annual retraining of infection prevention and control in 2013. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure staff receive retraining on infection prevention and control as outlined in O. Reg 79/10 s. 219(4) on an annual basis, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there are measures in place to prevent the transmission of infections.
The following wall mounted hand sanitizers were found throughout the home to be expired:
- Outside residents' rooms #109, #111, #211, #212, #235, #312, #313, #317, #324, expired date October 2011
- Outside the tub room at cottage house, expired date October 2011
- Outside residents' rooms #101, #302, expired date December 2011
- Outside resident room #215, expired date November 2012
- Outside the shower room at country house, expired date February 2012
- Main lobby near information station window, expired date December 2011

The ED was informed and arrangements were made to have expired hand sanitizers replaced. [s. 86. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.
On April 11, 2014, at 12:03p.m. medication was found on the floor in the television lounge of an identified home area. There were no residents or staff present when discovered. This was brought to the attention of the registered staff who indicated additional follow-up would occur. When interviewed later the registered staff indicated the medication was similar to the medication administered to resident #5024 earlier in the shift. A review of the progress notes revealed a late entry documentation indicating the resident had spit out the medication when administered at 12:00p.m. The DOC was informed and indicated follow-up would take place. [s. 126.]

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 drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) On April 4, 2014, at 3:35p.m. in an identified home area, a registered staff was observed to dispense and administer medications to five residents without performing hand hygiene between each of the residents. An interview was conducted with the registered staff who confirmed hand hygiene should have been performed performed when dispensing and administering the medications between each resident. An interview with the DOC confirmed that hand hygiene is to be performed prior to preparing and administering of medication to each resident.

b) On April 7, 2014, at 12:10p.m. on an identified home area a staff member was observed to provide physical assistance to walk a resident to the dining room and serve meals without performing hand hygiene.
When interviewed the registered staff confirmed staff should perform hand hygiene between residents. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered at each meal and snack.
a) During a lunch meal observation on April 7, 2014, the posted daily menu on an identified home area included chicken nuggets and plum sauce. It was observed that six residents that ordered the chicken nuggets did not receive plum sauce. An interview with dietary staff serving the meal stated the plum sauce was not available. An interview with the DDS stated the plum sauce was available (in a blue container) at the servery and that it should have been served.

b) Resident #5056's nutritional plan of care includes a nutritional supplement at morning and afternoon snack. Observations during the afternoon snack on April 4 and 7, 2014, identified the resident was offered the nutritional supplement and was not offered additional food or fluids as per the planned menu. An interview with a staff member revealed that the resident is not offered a snack from the planned menu because the resident receives a nutritional supplement. Interviews with the RD and DOC confirmed the nutritional supplement does not replace the planned snack and that the resident should be offered the planned snack in addition to the nutritional supplement. [s. 71. (4)]

Issued on this 28th day of April, 2014

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

L. Parsons, B. Parisotto, E. Tang, For M. Chiu