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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 23, 2014	2014_200148_0014	O-000360-14	Resident Quality Inspection

Licensee/Titulaire de permis

BROADVIEW NURSING CENTRE LIMITED
210 Brockville Street, Smiths Falls, ON, K7A-3Z4

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

BROADVIEW NURSING CENTRE
210 Brockville Street, Smiths Falls, ON, K7A-3Z4

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

AMANDA NIXON (148), BARBARA ROBINSON (572), WENDY PATTERSON (556)

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): May 12-16 and 20-21, 2014.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Quality Improvement Coordinator (QIC), Resident Assessment (RAI) Coordinator, Director of Activation, Housekeeping Supervisor, Maintenance Supervisor, Nutritional Manager, Registered Dietitian, Pharmacist, Registered Nurse Supervisor, Registered Practical Nurse (RPN), Personal Support Workers (PSW), family and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, housekeeping schedules and pet vaccination records. Policies were reviewed related to the medication management system, infection control and prevention and prevention of abuse and neglect of residents. In addition, resident care and meal service was observed.

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
Falls Prevention
Family Council
Food Quality
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

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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.16, whereby the licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

Inspector #556 observed resident rooms #116, #117, #118, #119, #121, #122 and #126, to have a window that opens to the outdoors, each window was observed to have an opening measuring approximately 61 centimeters at the widest point.

Inspector #148 observed a window that opens to the outside in resident room #102, to open approximately 20 centimeters at the widest point. The window is capable of opening further however, the resident's wardrobe is located in front of the window effectively blocking the window from opening further than 20 centimeters.

Inspector #148 observed all other resident rooms, excluding those observed by Inspector #556 and room #102, to have a window that opens to the outdoors, each window was observed to have an opening measuring approximately 50 centimeters at the widest point.

Inspector #148 observed the activity space and small dining area located near the entrance of the home. All three windows located in this area were observed to open approximately 23 centimeters at the widest point. [s. 16.]

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 windows opening to the outdoors that are accessible to residents do not open more than 15 centimeters, to be implemented voluntarily.

WN #2: 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 comply with O.Reg 79/10, s.17(1)(a), whereby the licensee did not ensure that the home's resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Resident #918, was observed by Inspector #148 on May 13, 2014 to be sitting in his/her room in a comfortable chair situated at the foot of the bed. The resident-staff communication and response system is located at the head of the bed. The call bell cord, attached to the communication system, reached to the middle of the bed and did not reach the area in which the resident was sitting. When asked by the Inspector, the resident was not able to reach the call bell cord, the resident indicated that if he/she needed to call for assistance the resident would need to get up out of the chair and get it. [s. 17. (1) (a)]

2. On May 12, 2014 at 11am Inspector #556 observed Resident #943 to be sitting in his/her bedroom in a wheel chair with the call bell cord of the communication response system approximately five feet away from the resident, attached to the side rail of the bed and out of reach of the resident.

A second observation occurred on May 12, 2014 at 2pm and Resident #943 was again sitting in the wheel chair in the middle of the room and the call bell cord of the communication and response system was attached to the side rail of the bed and out

of reach of the resident.

In an interview the Director of Care (DOC) stated the communication response system is expected to be within reach of a resident who is in their room whether they are in a wheel chair, bed, or stationary chair. The DOC further stated the staff are made aware of that expectation because communication response system accessibility is included in the resident care plans. The DOC reviewed the current care plan and stated that access to the communication response system was not included for Resident #943. The DOC also stated that staff are trained on orientation and annually regarding resident rights, and having the communication response system accessible to residents at all times when in their room is part of that training.

In an interview the Quality Improvement Coordinator (QIC) stated that communication response system accessibility is included in the care plan under the sections Aids to Daily Living, Sleep and Rest, and Bed Mobility. The QIC further stated that anything that is put on the care plan goes right to the Point of Care (POC) kardex so that PSW staff are aware. The tasks in POC were reviewed for Resident #943 and did not indicate that the resident was to have access to the communication response system when in his/her room in the chair.

In an interview PSW staff member #S104 who has worked in the home for three weeks stated that when they received orientation Resident's Rights were part of the training, and communication response system accessibility was included. Staff member #S104 stated that their understanding is that the communication response system is to be accessible to residents at all times when they are in their room. [s. 17. (1) (a)]

3. On May 14, 2014 Resident #945 was observed sitting in a wheelchair near the foot of the resident's bed. The communication and response system was located at the head of the bed. The call bell cord attached to the communication system was laying on the resident's bed and out of reach of the resident. [s. 17. (1) (d)]

4. The licensee failed to comply with O.Reg 79/10, s.17(1)(e), whereby the licensee did not ensure that the home's resident-staff communication and response system is available in every area accessible by residents.

Observations related to Stage 1 activities of the Resident Quality Inspection indicated that a resident-staff communication system could not be located in the large dining

room, small dining room or activity space, all of which are located near the entrance of the home and were observed to be used by residents throughout the inspection.

On May 15, 2014, Inspector #148 spoke with Registered Nurse staff member #105 and two PSW staff members #S107 and #S108, who each reported that there is no resident-staff communication and response system located in the large dining room, small dining room or activity space, all of which are areas accessible by residents. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication system is accessible to residents at all time and is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.85(3), whereby the licensee did not ensure that the advice of the Residents' Council was sought out in the development and carrying out of the survey.

On May 16, 2014, Inspector #148 spoke with the Resident Council President who reported that prior to the implementation of the last satisfaction survey, the advice of the resident council was not sought out by the licensee.

On May 16, 2014, Inspector #148 spoke with the home's Administrator who reported that the last satisfaction survey was implemented November 2013. The Administrator reported that the survey was reviewed and input was received from the coffee group (defined as a social gathering of residents), but that advice from the residents' council was not obtained for the development and carrying out of the survey. [s. 85. (3)]

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 advice of the Residents' Council is sought out in the development and carrying out of the survey, 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 has failed to comply with O. Reg. 79/10, s. 129 (1) (b), whereby the licensee did not ensure that 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.

On May 15, 2014 Inspector #572 observed Lorazepam 0.5 mg tablets stored in resident medication compartments within the medication cart designated for Resident #3 and Resident #941. These controlled drugs were not stored in a separate locked area within the locked medication cart.

On May 15, 2014 Inspector #572 observed two vials of stock injectable Lorazepam in the unlocked medication fridge within the locked medication room. The controlled drugs were not stored in a separate double-locked stationary fridge in the locked area.

On May 15, 2014 Registered Nurse Supervisor S#105 and the DOC both confirmed that no Benzodiazepine drugs (as listed in Schedule IV of the Controlled Drugs and Substances Act) are stored in a separate double locked area OR stored in a separate locked area within the locked medication cart. [s. 129. (1) (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 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, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 6 (1) (a), whereby the licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident.

The most recent care plan for Resident #929 indicates that the resident requires glasses. The resident was not observed to wear glasses and there were no glasses observed with the personal care items in the bedside dresser of Resident #929. The most recent Minimum Data Set (MDS) assessment states that the resident does not use glasses. The RAI Coordinator stated that the resident no longer wears glasses and that the plan of care was not accurate and required an update. Registered Nurse Supervisor staff member #S105 and RPN #S117 confirmed that Resident #929 does not wear glasses. The plan of care does not set out the planned care for Resident #929, as it relates to the use of glasses. [s. 6. (1)]

2.A review of the care plan on the Resident's health care record indicates that catheter care is required for Resident #926. Inspector #556 observed Resident #926 and could find no indication that the resident had a catheter.

In an interview the RAI Coordinator stated that on a specified date Resident #926 was admitted to hospital and remained there for several days. Prior to going to the hospital the resident had been coded as frequently incontinent, however after coming back from the hospital the resident has been on a restorative toileting program and is now coded as occasionally incontinent.

In an interview PSW staff member #S123 stated that Resident #926 used to have a catheter but the resident no longer does, and PSW staff member #S124 stated that Resident #926 does not have a catheter. The plan of care for Resident #926 does not set out the planned care for the resident related to use of a catheter.

3. The plan of care for Resident #973 indicates that the resident requires glasses. PSW staff member #S115 and Registered Nurse Supervisor staff member #S105, reported that the resident does not wear glasses, and neither could recall the resident having glasses in his/her possession. Staff member #S105 reviewed the resident's admission information and list of personal items, it could not be identified that the resident ever owned glasses while residing in the home. The plan of care for Resident #973 does not set out the planned care for the resident related to his/her vision impairment.

Resident #933 was observed to be seated in a wheelchair on several occasions throughout the inspection, when observed in the wheelchair the chair was in a tilt position. Registered Nurse Supervisor staff member #S105, reported that the tilt is applied to provide for comfort and positioning. The home's RAI Coordinator also reported that the tilt is applied when the resident is seated in his/her wheelchair, with the exception of meal time, to promote comfort and maintain positioning. The resident's plan of care was reviewed and does not include the resident's need for a tilt position when in the wheelchair. The plan of care for Resident #933 does not set out the planned care for the resident related to comfort and positioning when in his/her wheelchair.

Resident #921 was observed to be seated in a wheelchair, on several occasions throughout the inspection, when observed in the wheelchair a table top was applied. Registered Nurse Supervisor staff member #105, reported that the table top is primarily in place to assist the resident with eating at meals and beverage/snack passes. The plan of care for Resident #921 was reviewed and there was no description of the resident's need for a table top during meals and beverage/snack passes. The plan of care for Resident #921 does not set out the planned care for the resident related to the use of a table top. [s. 6. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.12 (2) (e), whereby the licensee did not ensure that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so.

Resident #923 was observed not to have a chair for his/her use in his/her side of the room that the resident shares with another co-resident.
Resident #923 stated he/she used to have a chair in his/her room that he/she often sat in, but after a room-mate was admitted the chair was removed from his/her side of the room and placed on the other side of the room for the room-mate's use. He/she further stated that he/she misses having the chair. Inspector #556 observed the chair the room-mate is using to be one of the upholstered straight back chairs used in the dining room.

In an interview the Director of Activation (DOA) stated he/she was part of the moving in of Resident #923's room-mate, and he/she doesn't remember the chair being moved. The DOA further stated that every resident is entitled to have a four point chair in their room.

In an interview the DOC stated that she/he remembers seeing someone pick up the chair and move it over to the other side of the room when the room-mate was being admitted and it just never crossed anybody's mind to get another chair for Resident #923.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA , 2007, S.O. 2007, c.8, s. 15. (2) (a,) whereby the licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary.

On May 13, 2014, Inspector #148 observed that the wheelchair used by Resident #973 had visible food debris along the seat prior to the breakfast meal service, the debris was observed to remain during a mid morning observation. On May 14, 2014 Inspector #556 observed that the base of the wheelchair used by Resident #942 had a layer of dust and was generally unclean.

RPN staff member #S118 and PSW staff member #S113 stated that a "Midnight Cleaning Checklist" binder contained records of the residents' wheelchair and walker cleaning schedule as per Equipment Cleaning Policy (RCSM M-30). Checklists in the binder were not completed on numerous dates. The home's DOC reviewed the cleaning checklists with Inspector #541 and confirmed that resident wheelchairs and walkers are not documented as being cleaned as per the home's policy. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.68(1)(e)(ii), whereby the licensee did not ensure that the weight monitoring system measures and records, with respect to each resident, the height upon admission and annually thereafter.

On May 13, 2014, Inspector #148 reviewed the health care records of fourteen residents. It was found that for each resident the most recent height documented was from the year 2012.

On May 15, 2014, Inspector #148 interviewed the Director of Nutritional Services who indicated that she was aware that heights were not completed in 2013 or to date in 2014. She noted that only residents who have been newly admitted during that time have had a height measurement.

On May 15, 2014 Inspector #148 interviewed Registered Nurse staff member #105 who indicated that she is not aware of a process by which residents heights are measured on an annual basis. [s. 68. (2) (e) (ii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 97 (1) (a), whereby the licensee did not ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury to pain to the resident or that causes distress to the resident that could potentially be detrimental to the Resident's health or well-being.

On a specified date Resident #009 sustained a laceration after he/she was hit by Resident #001.
A review of Resident #009's health care record indicates that the contact for personal care for the Resident is a Public Guardian and Trustee employee.

A review of the progress note on Resident #009's health care record documenting the incident indicates that the Public Guardian and Trustee were called regarding the incident but that no one answered the phone and no message could be left, staff were to follow up on the following Monday. A further review of the progress notes was conducted and there is no indication that a follow up call to Public Guardian and Trustee was made.

In an interview the DOC stated that she is not aware of the follow up call being made to Public Guardian and Trustee regarding the incident of Resident to Resident abuse with injury.

In an interview the Registered Nursing Supervisor #S105 stated that she did not call the Public Guardian and Trustee because she was given direction by the DOC that Resident #009 is his/her own POA and therefore a call to Public Guardian and Trustee was not required.

WN #10: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 229 (2) (e), whereby the licensee did not ensure that a written record is kept relating to each annual evaluation of the infection control program that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

In an interview on May 16, 2014 the DOC stated that she is the lead in the home for the Infection Prevention and Control Program and that while she evaluates the program annually, it is done informally and there is no written record kept relating to the evaluation. [s. 229. (2) (e)]

2. The licensee has failed to comply with O. Reg 79/10, s. 229 (10) 1., in that the licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #008 was admitted to the home on a specified date and according to the documentation in the Resident's health care record Step 1 of the 2 Step Mantoux Skin Test was administered on the following day to begin the process of screening for tuberculosis. However, there was no documentation to
indicate that Step 2 of the 2 Step Mantoux Skin Test was ever administered.

There was no documentation on Resident #008's health care record to indicate that any other method of tuberculosis screening was done by the home, nor are there documented results of tuberculosis screening done in the 90 days prior to admission to the home.

In an interview the DOC stated that she was not able to locate documentation to indicate that Resident #008 had received his/her Step 2 Mantoux Skin Test. The DOC further stated that at the time of Resident #008's admission the home was in the process of changing their tuberculosis screening practice and as a result there was a little bit of confusion and this Resident's Step 2 appears to have been missed.

In an interview the QIC stated that he thought he had administered the Step 2 because that is the home's policy and he always follows policy, however the QIC was not able to locate documentation to confirm that Step 2 of the 2 Step Mantoux Skin Test had been administered.

Issued on this 23rd day of May, 2014

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

Amanda Nixon RD LTCH Inspector