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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 18, 2015	2015_376594_0028	026483-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE KIRKLAND LAKE
155 GOVERNMENT ROAD EAST P.O. BAG 3900 KIRKLAND LAKE ON P2N 3P4

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

MONIKA GRAY (594), LINDSAY DYRDA (575), MARIE LAFRAMBOISE (628), VALA MONESTIME BELTER (580)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 05-09 and 13-16, 2015.

This inspection includes critical incident reports the home submitted related to allegations of abuse to a resident, a missing resident, an injury to a resident for which they were taken to hospital. This inspection also includes a complaint related to staffing levels affecting resident care.

This inspection includes Log #009356-15, #025875-15, #025893-15, #025897-15, #025957-15.

During the course of the inspection, the inspector(s) spoke with Residents, Resident's Family/Substitute Decision Maker (SDM), Personal Support Workers (PSWs), Dietary Aide, Housekeepers, Maintenance staff, Registered Practical Nurses (RPNs), Registered Nurses, Director of Care and the Administrator.

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

On October 05 and 08, 2015, Inspector #575 observed resident #008 in bed with one bed rail in the upright position. The inspector asked the resident how many bed rails they usually require and the resident indicated that they only use one bed rail to assist with bed mobility.

The inspector reviewed the resident's plan of care including the bed system logo inside the resident's closet which indicated that the resident required two bed rails. The resident's electronic care plan was reviewed by the inspector and indicated that both bed rails were to be secured in the upright position to assist the resident with repositioning.

During an interview with the inspector, PSW #115 indicated that the resident only used one bed rail.

During an interview, RN #102 indicated that the care plan was not correct and that it would need to be updated to reflect the resident's needs and preferences. [s. 6. (2)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of

the resident and the resident's needs and preferences.

On October 08, 2015, resident #009 stated to the inspector that oral care was performed in the evening and again in the morning, but that they only prefer to have oral care performed by staff in the evening.

The inspector reviewed the resident’s plan of care which indicated that the goal for the resident’s oral status was to perform oral care after each meal.

Review of the home's Care Planning policy #03-01-02 date of origin September 2010 indicated that Registered Staff and other members of the interdisciplinary care team are responsible for updating the resident's plan of care to ensure it remains current and reflective of the care needs of the resident at any given point in time.

The inspector interviewed PSW #126 who indicated that the resident will refuse oral care many times and staff will approach throughout the day, but the resident will refuse.

In an interview with the inspector, RPN #125 indicated that the resident does refuse oral care throughout the day and that the care plan should be updated to reflect the resident's preferences. [s. 6. (2)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #010 was provided to the resident as specified in the plan.

On October 06, 07, 08, 13, and 14, 2015, the inspector observed resident #010 in bed with two bed rails in the upright position.

The inspector reviewed the resident’s plan of care including the Bed System Logo which indicated that the left bed rail was to be in a horizontal position, and the right bed rail was to be in the 'upright' position to aid the resident with positioning.

On October 14, 2015, the inspector interviewed PSW #128 who confirmed that the bed rails were not in place as identified in the plan of care.

On October 15, 2015, the inspector observed, again, both the left and right bed rails for resident #010 in the upright position contrary to the plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care for resident

#010 was provided to the resident as specified in the plan.

In a staff interview on October 06, 2015, RPN #125 indicated to Inspector #594 that resident #010 had altered skin integrity to a certain area.

On October 06, 2015, the inspector observed the resident with altered skin colour and skin integrity to an area on the resident's body. On October 07, 08, 13 and 14, 2015, the inspector observed the resident with a dressing applied to the area.

Review of the care plan for resident #010 documented that an intervention to the skin issue was to ensure a specific dressing was to remain in place when the resident was at rest in their wheelchair, bed, or while seated in the dining room.

In separate interviews with RPN #125 and the DOC, it was indicated to the inspector that the resident had returned from a leave of absence with a dressing that had been wrongly applied to the resident's specific area, and that is what the inspector had observed on the resident. RPN #125 indicated to the inspector that the wrongly applied dressing may have been causing the skin integrity to the resident's certain body area to deteriorate. [s. 6. (7)]

5. The licensee has failed to ensure that resident #010 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

On October 13 and 14, 2015, Inspector #594 observed resident #010 with a device attached to the back of the resident's clothing while seated in the dining room.

The inspector reviewed the resident's plan of care which failed to identify use of a device.

The inspector reviewed the Monthly Restraint Report dated for a month in 2015, which indicated that resident #010 had two devices and that staff were directed to chart for one week regarding one of the devices, then discontinue use of that device.

Review of the home's Care Planning policy #03-01-02 date of origin September 2010 indicated that Registered Staff and other members of the interdisciplinary care team are responsible for updating the resident's plan of care to ensure it remains current and reflective of the care needs of the resident at any given point in time.

During an interview with the inspector, PSW #128 and RPN #129 stated that the resident

requires a device when in the dining room. PSW #128 indicated they received the direction to apply the device from registered staff but could also find the information on the resident's Kardex. The inspector along with PSW #128 and RPN #129 reviewed the resident's Kardex which failed to identify direction to apply the device.

Inspector #594 and the DOC reviewed the historical care plan for resident #010, the DOC verified the plan of care failed to document the use of a device. The DOC indicated to the inspector that the one device was discontinued but the second device should have been documented on the care plan. [s. 6. (10) (b)]

6. The licensee has failed to ensure that resident #013 was reassessed and the plan of care reviewed and revised when care set out in the plan of care had not been effective.

Inspector #575 reviewed a report to the Director that indicated during 2015, resident #013 was missing from the home for approximately 20 minutes. As a result, a device was applied to the resident's walker.

The inspector reviewed the resident's most recent care plan which indicated that the resident had a device in place on their body, and a device on their wheelchair.

On October 13, 2015, the inspector observed the resident and noted the resident did not have a device applied to their body.

During an interview with RPN #114, the inspector told RPN #114 that the resident's care plan indicated that the resident was to have a device on the resident's body, however the inspector did not observe the device in place. RPN #114 indicated that the resident has removed the device from their body in the past. RPN #114 then reviewed the progress notes and told the inspector that a device was applied during 2015, and further added that the resident removed the device applied to their body on the same day (however there were no notes to support this). RPN #114 confirmed that the resident had a device on their walker and wheelchair, however they did not have one on their body as indicated on the care plan. [s. 6. (10) (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: the plan of care reflects resident #008's preference for bed rails and resident #009's preference for oral care; for resident #010 the care set out in the plan of care regarding bed rails is provided to the resident and that their plan of care is reviewed and revised to reflect the assessed use of a device; and that the plan of care for resident #013 is reviewed and revised to reflect the assessed use of a device, 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 has failed to ensure that the Continence Management Program Policy was complied with.

On October 07, 2015, Inspector #575 observed resident #006 sleeping in their bed and the resident's bed sheets were soiled. PSW #110 confirmed to the inspector that the resident was incontinent.

The home's policy titled Continence Management Program # RESI-10-04-01, version November 2013, indicated that the staff would complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. The assessment is to be completed upon a resident's admission, with any deterioration in continence level, at required jurisdictional frequency if different from above, and with any change in condition that may affect bladder and bowel continence.

The inspector reviewed the resident's most recent quarterly continence assessment completed during 2015. The inspector noted that the assessment was not completed as required and was missing relevant information regarding what toileting pattern and product was used for the day and night, frequency of toileting on each shift, food and fluid assessment summary and actions.

During an interview on October 16, 2015, the DOC indicated that the quarterly assessment completed during 2015, was not completed as required. [s. 8. (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 for resident #006 and any other resident requiring continence assessments, the Continence Management Program Policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff.

In a report submitted to the Director during 2015, it was indicated that an investigation had been initiated because of alleged abuse and neglect of three residents. According to the report PSW #119 observed PSW #121 having been abusive to residents, and had neglected residents in providing assistance with activities of daily living.

Review of the home's investigation, indicated that PSW #119 observed over a three week period in 2015, when it was reported to the Administrator, PSW #121 to have been abusive to residents, and had neglected residents in providing assistance with activities of daily living. According to the same investigation, when asked why these incidents were not reported immediately, PSW #119 responded that they were terrified of PSW #121 and PSW #121 would know who reported them.

The inspector also reviewed a Disciplinary Notice for PSW #121 dated in 2014, which indicated that PSW #121 received a disciplinary action for behaviour infraction and policy violation where PSW #121 was observed to be abusive towards a resident.

Inspector #628 reviewed the Home's Resident Abuse-Staff to Resident policy reference #OPER-02-02-04 dated November 2013 (policy in effect during the November 2014 incident) which stated that if abuse was substantiated the process results in immediate termination of the employee.

Review of the home's Resident Abuse-Staff to Resident policy reference# OPER-02-02-04 dated September 2015 indicated that there is zero tolerance of abuse towards a resident and that all staff who have reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff are to immediately report to the Administrator, Director of Care and contact the Ministry of Health and Long-Term Care (Director) and is protected by legislation (Whistle-blowing protection) from retaliation.

The Administrator confirmed to Inspector #628 that the 2014 abuse investigation for PSW #121 was substantiated. According to the report submitted to the Director and the 2015 termination notice to PSW #121, a second incident of abuse was substantiated. [s. 19. (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 that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

In a report submitted to the Director during 2015, it was indicated that an investigation had been initiated because of alleged abuse and neglect of three residents. According to the report PSW #119 observed PSW #121 having been abusive to residents, and had neglected residents in providing assistance with activities of daily living. According to the same report PSW #121's employment was terminated in 2015.

Review of the home's investigation, indicated that PSW #119 observed over a three week period in 2015, when it was reported to the Administrator, PSW #121 to have been abusive to residents, and had neglected residents in providing assistance with activities of daily living. According to the same investigation, when asked why these incidents were not reported immediately, PSW #119 responded that they were terrified of PSW #121 and PSW #121 would know who reported them.

Review of the home's Resident Abuse-Staff to Resident policy reference# OPER-02-02-04 dated September 2015 indicated that there is zero tolerance of abuse towards a resident and that all staff who have reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff are to immediately report to the Administrator, Director of Care and contact the Ministry of Health and Long-Term Care (Director) and is protected by legislation (Whistle-blowing protection) from retaliation. The witnessed abuse of residents by PSW #121 over the three week period was not immediately reported as per the home's abuse policy.

The inspector also reviewed a Disciplinary Notice for PSW #121 dated in 2014, which indicated that PSW #121 received a disciplinary action for behaviour infraction and policy violation where PSW #121 was observed to be abusive towards a resident.

Inspector #628 reviewed the Home's Resident Abuse-Staff to Resident policy reference #OPER-02-02-04 dated November 2013 (policy in effect during the November 2014 incident) which stated that substantiated abuse process results in immediately termination of the employee.

The Administrator confirmed to Inspector #628 that the 2014 abuse investigation for PSW #121 was substantiated and that the home's Resident Abuse-Staff to Resident policy was not complied with in 2014. [s. 20. (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 that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

It was identified during the transition into Stage II of the inspection, that resident #008 had altered skin integrity according to the most recent Resident Assessment Instrument Minimum Data Set (MDS) assessment. Inspector #575 reviewed the resident's health care record and noted that the MDS assessment date in 2015, indicated that the resident had altered skin integrity. The inspector noted that according to the progress notes, the

altered skin integrity was discovered in 2015, and was resolved three months later.

During an interview RN #102 indicated that when a resident has altered skin integrity, staff are to complete a weekly assessment (re-assessment).

Inspector #575 reviewed the resident's health care record and noted that on two occasions, the weekly re-assessment was not completed as required. An assessment was completed during a month in 2015, then not until 13 days later and an assessment was completed during another month in 2015, then not until 19 days later.

During an interview RPN #114 confirmed that the weekly re-assessments were not completed as required. [s. 50. (2) (b) (iv)]

2. In a staff interview on October 06, 2015, RPN #125 indicated to Inspector #594 that resident #010 had two areas of altered skin integrity.

The inspector reviewed the resident's health care record where it was documented on two assessments that the resident had developed an area of altered skin integrity upon return from a leave of absence during 2015.

Review of the home's Pressure Ulcers policy #03-07 date of Origin June 2010 documented that the Skin Care Coordinator or delegate will assess and document the assessment of all pressure wounds that are greater than Stage II weekly.

In an interview with Inspector #575, RN #102 and RPN #114 indicated that a weekly assessment is to be completed for any altered skin integrity. During an interview with Inspector #594 on October 14, 2015, RPN #125 indicated that an area of altered skin integrity on resident's body had deteriorated.

A progress note dated during 2015 documented that an area of altered skin integrity remains on the resident's body.

The inspector and DOC reviewed the weekly assessment for resident #010. The DOC indicated to the inspector that a weekly assessment had not been completed for resident #010's two areas of altered skin integrity as required. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for resident #008 and #010 and any other resident exhibiting altered skin integrity, a reassessment is completed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with 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 ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies and that was secure and locked.

On October 06, 2015, Inspector #580 observed two containers of an ointment on the bedside table of resident #004. On the same day, Inspector #575 observed one container of an ointment on the bedside table of resident #020. On October 14, 2015, Inspector #575 confirmed that the two containers of ointment remained on the bedside table of resident #004, and the one container of an ointment remained on the bedside

table of resident #020.

Inspector #575 interviewed RN #122 and RPN #123 regarding the storage of medicated cream/ointment. RN #122 indicated that no medications should be left at the resident's bedside. RPN #123 indicated that the ointment is to be stored in the locked medication room. RPN #132 confirmed to the inspector that residents #004 and #020 did not have a physician's order for the ointment or to keep medications at their bedside.

Additionally, on October 06, 2015, Inspector #575 observed a bottle of medication on top of an unsupervised medication cart in the east hallway on the second floor. RPN #101 was observed to walk down the hallway from the nursing station towards the medication cart and indicated that the medication was not supposed to be left on top of the medication cart and proceeded to place the bottle of medication in the locked medication cart.

On October 14, 2015, the DOC advised the inspector that on one occasion when administering medications on the third floor, they had observed a tube of topical gel at the bedside of resident #023. The DOC indicated that the family had brought it in without the knowledge of the staff. The DOC confirmed that there was a physician's order for the medication, however, there was no order to leave at the resident's bedside. The DOC was not sure if the medication was removed from the resident's bedside.

On October 14, 2015, the inspector observed resident #023's room. The inspector observed ointment on top of the bedside table and a topical gel inside the beside table drawer. Both medications were not labelled. The inspector reviewed the resident's health care record and noted a physician order for the topical gel, however there was no physician order for the ointment or to leave the medications at the resident's bedside. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were 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 October 14, 2015, Inspector #575 observed the medication room on the second floor with RN #122. The inspector observed and RN #122 confirmed, that the 'extra' controlled substances were locked in a separate locked stationary cupboard, however, it was not double-locked as required. [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 all drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies and that is secure and locked, additionally 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 #7: 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 staff participate in the implementation of the infection prevention and control program.

On October 14, 2015, Inspector #575 observed RPN #114 administer medications to three residents (#020, #007, #021).

The inspector observed RPN #114 enter resident #021's room to examine the resident and ensure the resident's medicated patch remained applied. Hand washing was not completed before or after RPN #114 entered the resident's room.

RPN #114 then prepared medications for resident #007 (oral medication and an injectable medication). The inspector observed RPN #114 enter the resident's room and administer the medications orally and by injection. Hand washing was not performed before or after the administration.

RPN #114 then prepared medications for resident #021 (oral medication and eye drops). RPN #114 administered the medications, including eye drops in each eye. Hand washing was not performed before or after administration.

During an interview, the DOC indicated that during medication administration, hand hygiene is to be performed between each resident. [s. 229. (4)]

2. On October 16, 2015, at 1025 hours in the second floor dining area, Inspector #580 observed RPN #132 performing an ear assessment on resident #024, then prepare and administer medication to two residents (#025 and #026) including a blood glucose test. Hand washing was not performed before or after the ear assessment nor the medication administration.

The home's policy titled 'Hand Hygiene Program #INFE-02-01-06 version January 2015, indicated that staff are to perform hand hygiene during the four moments of hand hygiene which included before initial resident/environment contact, before aseptic procedure, after body fluid exposure, and after resident/environment contact.

RPN #132 confirmed to the inspector that they usually have hand sanitizer on the medication cart but had forgotten to place it there. [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 that staff participate in the infection prevention and control program, specifically hand washing, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #022 was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity.

On October 15, 2015, at approximately 1520 hours, Inspector #575 observed resident #022 participating in a program with physiotherapy staff (Physiotherapy Staff #134 and Physiotherapy Staff #135). The inspector noted that the resident had been incontinent, and overheard a staff member indicate that they were almost done assisting the resident in the program. The resident continued to participate in the program for approximately three minutes, and then was observed to sit in their wheelchair to rest. The resident was then taken to their room via their wheelchair where they waited for approximately five minutes before being assisted to change their soiled clothes by staff.

The resident's electronic care plan (hard copy obtained), indicated that the resident required extensive assistance of two staff for toileting and to offer toileting assistance to the resident every hour as the resident had a hard time remaining continent. The inspector noted that the resident did not appear to know that they were soiled. The care plan also indicated that the resident had short and long term memory loss and confusion to person, place and time. [s. 3. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing care to resident #009 was held within six weeks following the resident's admission.

In an interview with the inspector, RN #111 indicated that an Interdisciplinary Team Care Conference (IDTC) meeting was to be documented in the IDTC meeting notes under the assessment tab in Point Click Care (PCC). The inspector and RN #111 reviewed resident #009's health care record which did not identify any IDTC meeting.

Review of the home's Interdisciplinary Team Conference: Organizing Guidelines policy #RESI-03-01-03 Reviewed December 2002 indicated that the evaluation guideline for organizing and implementing interdisciplinary team conferences should take place at the end of a designated time period. Success of evaluation is dependent on specificity of goals and strategies. The interdisciplinary team should be involved in revamping the care plan at designated times. The home's Admission Assessment and Interdisciplinary Conference policy #RESI-03-01-04 reviewed December 2002 indicated that the interdisciplinary team participates in an admission conference within the first 4 weeks of admission of a resident and to record the results of the conference on the multidisciplinary conference record.

In an interview with the inspector, both RN #102 and RPN #125 indicated there was no documentation indicating that resident #009 had received a care conference of the interdisciplinary team providing the resident's care within six weeks following the resident's admission.

The DOC and Administrator confirmed that there was no care conference held within six weeks following admission for resident #009. [s. 27. (1)]

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.