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
Sep 15, 2014	2014_168202_0014	T-033-14	Resident Quality Inspection

Licensee/Titulaire de permis

CLURELEA LTD.
272 QUEEN STREET EAST, BRAMPTON, ON, L6V-1B9

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

GOOD SAMARITAN NURSING HOME
481 Victoria Street East, Alliston, ON, L9R-1J8

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

VALERIE JOHNSTON (202), ANN HENDERSON (559), BARBARA PARISOTTO (558)

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): July 23, 24, 25, 28, 29, 31, August 01, 05, 06, 07, 08, 2014.

During the course of this inspection the following complaint inspection was completed: T-662-13

During the course of the inspection, the inspector(s) spoke with the administrator/director of nursing (DON), director of resident care (DRC), nutrition manager (NM), rai-director, environmental services supervisor (ESS), dietitian, activity director, registered nursing staff, nursing student, dietary aides (DA), personal support workers (PSW), health care aides (HCA), housekeeper, residents, families.

During the course of the inspection, the inspector(s) observed the provision of care, conducted a tour of the home, observed lunch meal services, observed resident beds, reviewed clinical records, reviewed food temperature records, night shift equipment cleaning schedule and housekeeping audit, reviewed Residents' Council meeting minutes for January 2014-July 2014 and food committee minutes for March, April, July 2014, reviewed the home's policies related to infection control, abuse, neglect, lifts and transfers, minimizing of restraining, responsive behaviours, meal services.

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

During the inspection it was observed that three sets of fire doors leading from three resident home areas to corridor S6, S8, and S9, all non-residential areas, were not equipped with locks to restrict unsupervised access. The ESS and the administrator confirmed these doors were not equipped with locks to restrict unsupervised access to the above non-residential areas. [s. 9. (1) 2.]

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 doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Resident #042's plan of care identified the resident as having fragile skin, limited bed mobility and two person staff assistance for care and transfers. A review of the resident's clinical records indicated that on an identified date, he/she was found with bruising.
PSW #118 indicated in an interview that upon noticing the bruises on the resident, he/she reported to an identified registered nurse an incident that occurred on an identified date. PSW #118 indicated that he/she was providing personal care to the resident with PSW #128. PSW #118 indicated that PSW #128 grabbed the resident while the resident was lying flat on his/her back and pulled him/her to a side lying position.
PSW #128 indicated in an interview that PSW #118 was noticed to be rushed while providing the resident with care. As PSW# 118 turned the resident from back lying to side lying with the use of a turning sheet, PSW #128 grabbed the resident in order to assist with the transfer. PSW #128 indicated that grabbing the resident was not intentional, however, the turning and repositioning of the resident was rushed causing injury to the resident. An interview with the DRC indicated that PSW #128 did not use appropriate transferring and positioning techniques when assisting the resident. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

a.) On July 28, 2014, at 11:30 a.m. the inspector observed in the south dining room a glass of milk placed on a table where residents had yet to be seated. At 11:50 a.m. the dietary aide was asked to take the temperature of the milk which was 20 degrees celsius.

At 12:19 p.m. the inspector observed in the north dining room a glass of milk placed on a table where residents had yet to be seated. At 12:34 p.m. the dietary aide was asked to take the temperature of the milk which was 13.7 degrees celsius.

A record review and staff interviews confirmed cold items should be kept within one to four degrees celsius. Interviews with a DA and the NM confirmed the temperature of the milk was in the temperature danger zone and was not acceptable.

b.) On July 29, 2014, at 12:07 p.m. the dietary aide in the south dining room took the temperatures of the lunch menu items prior to meal service. The fish burger was 102 degrees fahrenheit and the pureed salad was 50 degrees fahrenheit.

Interviews with the DA and NM confirmed hot foods should be served at 160 degrees fahrenheit and cold foods should be served at 40 degrees fahrenheit or under. [s. 73. (1) 6.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Resident #001's plan of care identified the resident as having two 3/4 length side rails raised while in bed to prevent an unintentional fall from the bed. Staff interviews indicated that the resident uses both 3/4 length side rails raised while in bed to prevent the resident from sliding and falling out of bed. Staff indicated that the resident has limited bed mobility and would only be able to use the side rail when staff are providing personal care. Staff indicated that the resident would not be able to

reposition him/herself, should he/she move into a compromised position. An interview with registered staff and the DRC confirmed that the resident uses both 3/4 length side rails raised while in bed and the bed rail restraint device had not been ordered by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

2. Resident #008's plan of care identified the resident as having two 3/4 length side rails raised while in bed to prevent an unintentional fall from bed and uses a therapeutic air mattress. Staff interviews indicated that the resident uses both 3/4 length side rails raised while in bed to prevent the resident from sliding and falling out of bed. Staff indicated that the resident has no bed mobility. Staff indicated that the resident would not be able to reposition him/herself, should he/she move into a compromised position and use pillows to support the resident to prevent him/her from rolling into the side rails. An interview with the DRC indicated that the 3/4 length side rails are only used on the resident's bed to support the use of a therapeutic air mattress. An interview with registered staff and the DRC confirmed that the resident uses both 3/4 length side rails raised while in bed and the bed rail restraint device had not been ordered by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

3. Resident #003's plan of care identified the resident as requiring two 3/4 length side rails raised when in bed and to be checked hourly. An assessment conducted on an identified date in 2013, concluded unintentional sliding from the bed was greater than the risk of entrapment and the registered nurse did not consider the side rails a restraint as the resident does not attempt to get out of bed. PSWs confirmed the resident would not be able to reposition him/herself when in a compromised position while in bed. An interview with the DRC confirmed the restraint device had not been ordered by a physician. [s. 110. (2) 1.]

4. Resident #007's plan of care identified the resident as requiring two 3/4 length side rails raised in bed and to be checked hourly. An assessment completed on an identified date, concluded the resident requires two side rails up when in bed to prevent unintentional sliding from the bed as there are no hi-lo beds available. The call bell is to be pinned to the resident to alert staff if potential entrapment occurs. PSWs confirmed the resident has tried to get around the rails and the bed is left at the highest height due to care. An interview with the DRC confirmed the restraint device had not been ordered by a physician. [s. 110. (2) 1.]

5. Resident #043's plan of care identified the resident as having two 3/4 length side

rails raised while in bed to prevent an unintentional fall from bed. Staff interviews indicated that the resident uses both 3/4 length side rails up while in bed to prevent the resident from unintentionally falling out of bed. On July 31, 2014, at 11:00 a.m., the resident was observed to be in bed with two 3/4 length side rails raised. The resident's lower legs were situated between the right upper and lower bars at end of the right side rail, while his/her head was situated at the top corner by the left side rail. An identified PSW indicated in an interview that the resident normally does not move in bed, however, the resident did appear to be in a compromised position. The PSW indicated that the resident does not actually need the side rails and indicated that he/she does not really know why they are used. The PSW indicated that the resident would not be able to reposition him/herself, should he/she move into a compromised position. A review of the clinical records indicated that on an identified date, the resident had been assessed for the use of 3/4 length side rails. The assessment for use form indicated that the resident does not climb out of bed, but may unintentionally fall out, and that there were no more hi/low beds available. An interview with registered staff and the DRC confirmed that the resident uses both 3/4 length side rails raised while in bed and the bed rail restraint device had not been ordered by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

6. The licensee failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Resident #001's plan of care identified the resident as having two 3/4 length side rails raised while in bed to prevent an unintentional fall from bed. Staff interviews indicated that the resident uses both 3/4 length side rails raised while in bed to prevent the resident from sliding and falling out of bed. Staff indicated that the resident has limited bed mobility and would only be able to use the side rail when staff are providing personal care. Staff indicated that the resident would not be able to reposition him/herself, should he/she move into a compromised position. Interviews with direct care staff confirmed that the 3/4 length side rails are considered a restraint and the resident is not monitored at least every hour when they are in use. [s. 110. (2) 3.]

7. Resident #003's plan of care identified the resident as requiring two 3/4 length side rails raised when in bed. PSWs confirmed the resident would not be able to reposition him/herself while in bed and that the 3/4 length side rails are considered a restraint. Registered staff and PSWs confirmed the resident is not monitored at least hourly

while restraints are in use. [s. 110. (2) 3.]

8. Resident #007’s plan of care identified the resident as requiring two 3/4 length side rails raised in bed. An assessment on an identified date, concluded the resident requires two side rails up when in bed to prevent unintentional sliding from the bed as there are no hi-lo beds available. The call bell is to be pinned to the resident to alert staff if potential entrapment occurs. PSWs confirmed the resident has tried to get around the rails and the bed is left at the highest height due to care. Registered staff and PSW's confirmed that the 3/4 length side rails used for the resident would be a restraint and the resident is not monitored while at least every hour when the restraint is in use. [s. 110. (2) 3.]

9. Resident #043’s plan of care identified the resident as having two 3/4 length side rails raised while in bed to prevent an unintentional fall from bed. On July 31, 2014, at 11:00 a.m., the resident was observed to be in bed with two 3/4 length side rails up. The resident’s lower legs were situated between the right upper and lower bars at end of the right side rail,the lower lengths of the side rails, while his/her head was situated at the top corner by the left side rail. An identified PSW indicated in an interview that the resident normally does not move in bed, however, the resident did appear to be in a compromised position. The PSW indicated that the resident does not actually need the side rails and indicated that the side rails would be considered a restraint device. Interviews with registered nursing staff and PSWs confirmed that when the side rails are used for the resident, the resident is not monitored at least hourly. [s. 110. (2) 3.]

10. Resident #008’s plan of care identified the resident as having two 3/4 length side rails raised while in bed to prevent an unintentional fall from bed and uses a therapeutic air mattress. Staff interviews indicated that the resident uses both 3/4 length side rails up while in bed to prevent the resident from sliding and falling out of bed. Staff indicated that the resident has no bed mobility. Staff indicated that the resident would not be able to reposition him/herself, should he/she move into a compromised position and use pillows to support the resident to prevent him/her from rolling into the side rails. Interviews with direct care staff confirmed that the side rails used for the resident would be considered a restraint and the resident is not monitored at least hourly when in use. [s. 110. (2) 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 where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class and that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class and that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose, to be implemented voluntarily.

WN #5: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On July 23, 2014, a nursing student was observed to be providing care to resident #010, in his/her room. The student nurse was gowned and gloved performing care on the resident. The resident's room mate was present and the privacy curtain nor the door to the room were closed. An interview with the nursing student confirmed that resident #010 had not been afforded privacy during care. An interview with a registered nurse indicated that the expectation is to keep doors closed while providing care to residents. [s. 3. (1) 8.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe environment for its residents.

During the course of this inspection, six residents' beds were observed to have ill-fitting mattresses which were slipping on the bed frames. The ESS confirmed the beds in the home had been audited, however, when observed with the inspector on August 6, 2014, confirmed that the mattresses in six identified rooms were ill fitting and would slip easily from the frame. The ESS further confirmed that the majority of residents' beds used in the home had mattresses that would slide on the bed frame and did not make for a safe environment. [s. 5.]

WN #7: 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. (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 that the provision of the care set out in the plan of care is documented.

A record review revealed resident #005 receives a labeled snack in the afternoon and evening related to low body weight and a history of weight loss. A review of the nutritional intake record for July 2014, revealed the provision of snacks was not documented on the following dates:

- afternoon snack on July 2, 5-20, 23-24, 2014 and
- evening snack on July 1-27, 2014.

Staff interviews with a PSW and the DRC confirmed that the provision of care was not documented. [s. 6. (9) 1.]

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

a) The resident's written plan of care updated on an identified date, identified the resident as having dentures. The staff are directed to provide routine teeth/mouth care five times a day and they are to remove and rinse his/his dentures after each meal when necessary and soak his/her dentures in cleansing solution for fifteen minutes each evening.
Interviews with PSWs revealed that the resident does not wear dentures and mouth care is provided twice a day.

b) The most recent minimum data set (MDS) indicated for resident #003 as having oral/dental problems. The plan of care revealed the resident had a dental assessment completed on an identified date, and there were several teeth broken down in an identified portion of his/her mouth. Recommendations were made that included extraction of some of the broken teeth.
An interview with the DRC confirmed that the recommendations set out in the plan of care by the dentist for the resident are no longer necessary and the resident's plan of care had not been reviewed and revised. [s. 6. (10) (b)]

3. The most recent minimum data set (MDS) indicated for resident #007 as having oral/dental problems. The resident's assessment summary sheet, revealed the resident had a dental assessment completed on an identified date, and recommendations were made. Dental notes indicated that the home has been waiting for physician approval for extraction of root tips, however, there is no further documentation in reference to this in either the physician notes or nursing notes.

An interview with the DRC confirmed that the recommendations set out in the plan of care by the dentist for the resident are no longer necessary and the residents plan of care had not been reviewed and revised. [s. 6. (10) (b)]

WN #8: 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 ensure that the home, furnishings and equipment are kept clean and sanitary.

a) On July 24, 2014, and July 29, 2014, the south shower room was observed to have soap scum stains on the half wall shelves. The tub room had a stained privacy curtain.

Staff interviews revealed tub and shower rooms are cleaned each Monday, Wednesday and Friday afternoons and privacy curtains are sent to laundry if stained and requires cleaning.
An interview with the ESS confirmed that the shower room and privacy curtain required cleaning.
On August 1, 2014, the south shower room and the privacy curtain in the tub room were clean.

b) On July 24, 2014, at 2:27 p.m., July 25, 2014, at 10:35a.m. and July 28, 2014 at 11:40a.m., the lift chair in the south tub room was dirty under the seat.
A record review revealed the lift chair used in tubs are to be cleaned and disinfected as part of the tub cleaning process.
An interview with a PSW and the DRC confirmed the lift chair was dirty.
The PSW proceeded to clean the chair immediately. [s. 15. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and that complies with manufacturer's instructions for the storage of the drugs.

An observation of the vaccine fridge on July 31, 2014, at 12:45 p.m. revealed that during the month of July 2014, the temperatures were not taken in the a.m. on July 23, July 24 and July 28 and in the p.m. on July 23. This was confirmed by the RN on duty. The temperatures in the refrigerator where the publicly funded vaccines are stored should be maintained between 2-8 degrees celsius and were noted in the temperature log to be above 8 degrees celsius on the following dates:
July 1 Max temperature 8.3 in the a.m.
July 2 Max temperature 8.2 in the a.m.
July 4 Max temperature 8.3 in the p.m.
July 6 Max temperature 8.7 in the p.m.
July 8 Max temperature 9.0 in the p.m.
July 9 Max temperature 9.5 in the a.m.
July 10 Max temperature 8.2 in the p.m.
July 16 Max temperature 8.8 in the p.m.
July 18 Current temp 9.5 and Max temperature 9.6 in the p.m.
July 19 Max temperature 9.5 in the a.m.
July 21 Max temperature 8.4 in the p.m.
July 22 Max temperature 8.3 in the p.m.
July 24 max temperature 9.0 in the p.m.
July 25 Max temperature 8.1 in the p.m.
July 29 Max temperature 8.3 in the p.m.
July 30 Max temperature 8.3 in the a.m. and 8.7 in the p.m.
The RN confirmed the temperatures were not in the acceptable range and that the publicly funded vaccines and insulin used daily are stored in the same refrigerator.

The administrator/DON confirmed that it is the expectation that the temperatures will be taken twice a day and logged in the temperature log book and any temperature out of range will be reported to the administrator/DON or DRC. [s. 129. (1) (a)]

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

Findings/Faits saillants :

1. The licensee failed to offer immunizations against tetanus and diphtheria to the residents in accordance with the publicly funded immunization schedules posted on the Ministry website.

A record review of the resident immunization records for resident #007, #010, #017, #018 and #019 revealed tetanus and diphtheria were not documented as offered. An interview with the DRC confirmed immunization against tetanus and diphtheria are not offered to residents. [s. 229. (10) 3.]

Issued on this 17th day of September, 2014

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