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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2015;	2015_157210_0001 (A1)	T-1686-15	Resident Quality Inspection

Licensee/Titulaire de permis

LABDARA FOUNDATION
5 Resurrection Road TORONTO ON M9A 5G1

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

LABDARA LITHUANIAN NURSING HOME
5 Resurrection Road TORONTO ON M9A 5G1

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

SLAVICA VUCKO (210) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The following Critical Incident Inspection was completed during this inspection: T-001441-14.

Issued on this 17 day of February 2015 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2015;	2015_157210_0001 (A1)	T-1686-15	Resident Quality Inspection

Licensee/Titulaire de permis

LABDARA FOUNDATION
5 Resurrection Road TORONTO ON M9A 5G1

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

LABDARA LITHUANIAN NURSING HOME
5 Resurrection Road TORONTO ON M9A 5G1

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

SLAVICA VUCKO (210) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 13, 14, 15, 16, 19, 20, 21, 23, 26, 27, 2015.

During the course of the inspection, the inspector(s) spoke with personal support workers(PSW), registered practical nurses (RPN), registered nurses (RN), director of care (DOC), administrator, physiotherapist (PT), dietary manager, registered dietitian (RD), environmental services manager (ESM), housekeeping aid, students, residents, families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Reporting and Complaints

Resident Charges

Residents' Council

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **11 WN(s)**
- **1 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 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,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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. (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 failed to ensure that the program is evaluated and updated at least annually in accordance with evidence-based practices.

The home's policy 9.0 Infection Protocols, subsection 9.10 Tuberculosis, revised March 2011, identifies that all residents admitted to the home are given a two step Mantoux skin test for tuberculosis. The home failed to evaluate this policy on an annual basis. The policy is not in compliance with evidence based practice as identified in Canadian Tuberculosis Standards, seventh edition, 2013. [s. 229. (2) (d)]

2. The licensee has failed to ensure 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.

The home uses a tool entitled "Audit Tool Infection Prevention and Control Programs in Long Term Care" as their evaluation of the program. The dates noted on this tool are conflicting. One date indicates December 5, 2014, and the other date identified is December 16, 201,4 as noted on the Licensee Confirmation Checklist. The DOC stated that he/she completes the audit and then reviews it with the team. Section 1.0 - Infection Prevention and Control Program, indicates ongoing evaluation and continuous improvement of the Infection Prevention and Control (IPAC) program, the DOC confirmed the audit tool is used as an evaluation. It does not include a summary

of the changes and the dates that those changes were implemented. [s. 229. (2) (e)]

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

During observation on January 26, 2015, at 11:14 a.m. the inspector noticed an identified staff wearing a personal protective equipment (PPE), a surgical mask on his/her neck. When asked why he/she wore the mask he/she answered that he/she just came out from a resident room where he/she was giving care to a resident who was on droplet precautions for respiratory symptoms.

Review of the policy infection control manual, personal protective equipment, revised March 2011, indicated masks are to be put on and removed according to best practices.

Review of the best practice guideline, Provincial Infection Disease Advisory Committee (PIDAC), for routine and additional precautions includes the following criteria for selecting masks and appropriate mask use:
- mask should securely cover the nose and mouth
- mask should be substantial enough to prevent droplet penetration
- mask should be able to perform for the duration of the activity for which the mask is indicated.

BOX 4: Appropriate Mask Use indicates:
-Remove mask correctly immediately after completion of task and discard into an appropriate waste receptacle.
-Do not allow mask to hang or dangle around the neck.
-Clean hands after removing the mask.

Interview with the IPAC leader indicated that masks are not supposed to be worn in hallways and they have to be discarded in the resident room where used, because they are considered contaminated. [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 the program is evaluated and updated at least annually in accordance with evidence-based practices, 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, staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

Review of the clinical record for resident #7 indicated he/she had eight falls in 2014 since the admission on November 1, 2013.
The falls were as follows:
-two falls in March 2014: during the first fall the resident was found on his/her knees in the bathroom; during the second fall the resident was found lying on the bathroom floor,
-in May, 2014, as per the resident's statement, he/she fell the night before beside the bed and sustained a bruise on the right side of the body,
-in June, 2014, the resident had two falls, one time he/she fell on his/her buttocks and hit the back of the head while walking with the walker in the room in presence of PSW; the second time the resident was found sitting on the floor in the room and fell when

tried to go to bathroom without calling for assistance,
-in July 2014, the resident was found kneeling at the bedside and per the resident he/she went to bathroom him/herself, came back and his/her feet gave up,
-in September, 2014, the resident was noted by staff sliding from the bed but could not reach him/her to prevent the fall, and
-in October 2014, early in the morning, the resident was found sitting on the floor (as per the resident he/she tried to go to the washroom and slid off the bed).

Review of the written plan of care indicated interventions to prevent falls that were created since the admission such as: "environmental precautions: check for hazards at least once per shift and attempt to reduce hazard, increase monitoring and supervision during busy time periods (early morning and bedtime, before and after meals and toileting), pain assessment and management, provide frequent rest periods".

After the first fall since the admission, the new intervention was "staff to encourage and advise the resident to call for assistance with activities of daily living (ADL)-for resident attempts activities on his/her own". After the last fall in 2014, the new intervention was "a personal alarm (sensor) to be pinned to gown when the resident was in bed".

Review of the falls management policy, revised on June 2010, identifies immediate interventions within 24 hours to reduce fall risk until more comprehensive care planning occurs, such as:
-increased toileting with specified frequency of assistance from staff,
-increased assistance targeted for specific high-risk times,
-increased monitoring using sensor devices or alarms,
-increased staff supervision targeted for specific high risk times,
-pain management,
-protective clothing (helmets, wrist guards, hip protectors),
-safe footwear,
-low bed or mat,
-specific behavior management strategies.

Interviews with identified PSWs and registered nursing staff confirmed the resident had a bed alarm applied since a particular day in October 2014, and a floor mat one month after, when the resident was transferred to another floor.

Interview with DOC, the leader of the falls management program, confirmed that

different approaches to prevent falls according to the falls prevention and management program were not considered in the revision of the plan of care in the period between the second fall in March, 2014, until the last fall in 2014. [s. 6. (11) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Observation made on January 13, 2015, at 10:20 a.m. noted three arm chairs in second floor lobby dirty with heavy stains on the cushions and the arm rests. A light color sofa chair was noted with heavy food stains on the seat and arm rests.

Interview with an identified housekeeping aide and the ESM confirmed that the chairs were not clean. The housekeeping aide stated that he/she was not responsible for the regular cleaning of the chairs. Interview with the ESM and record review indicated that cleaning of chairs in the lobby was within the daily job routine of the housekeeping aides.

Observation made on January 21, 2015, at 11 a.m. noted that the chairs had been cleaned and the food stains were removed. [s. 15. (2) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation made on January 14, 2015, at 11 a.m. noted resident #008 sleeping in bed with two quarter bed side rails in the up position. The call bell cord was noted hanging near the head and on the side of the bed about 2 inches from the floor. The resident was not be able to reach the call bell activation button in order to activate it when assistance was required.

Interview with an identified PSW student confirmed that the call bell was not accessible to the resident. The PSW student brought the call bell onto the bed and clipped it beside the resident so it would be easily accessible. Interview with an

identified RN confirmed that usually the resident was able to use the call bell and call for assistance when required, and that the call bell cord should be placed on the bed close to the resident for it to be accessible to the resident. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation made on January 13, 2015, at 10:20 a.m. revealed that the call bells in residents' lounges were not accessible. The call bell on third floor lounge was installed in the middle of a wall blocked by a keyboard placed in front of it. The call bell on second floor lounge had a cord attached and it was hidden behind branches of a large potted plant. The call bell on first floor had a sofa chair in front of it.

Interview with the ESM confirmed that the call bells were not accessible to the residents in their current locations being blocked by furniture and room decoration. The ESM stated that he/she will remove the furniture and the plant to ensure that call bells are accessible to residents. [s. 17. (1) (a)]

3. The licensee has failed to ensure that the resident-staff communication and response system uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Observations made on January 14, 2015, at 10:30 a.m., and January 15, 2015, at 11 a.m. on second floor noted that call bells from the tub room, the shower room, and seven identified resident's rooms and their adjacent washrooms in the north wing were not audible in the hallway outside the rooms. The call bells could be activated from their respective locations, the lights outside the rooms were observed on. However, the call bells were not audible in the hallway outside the respective rooms.

Interview with an identified PSW confirmed that the call bells were audible only when close to the nursing station which was more than 100 feet away and the hallway was winding which did not provide a clear view down the hallway. The PSW stated that staff used to carry pagers while on duty, however, the system broke down two years ago and was never replaced. The PSW stated that staff would not know when call bells were activated if they were located at the north end of the hallway.

Interview with the DOC confirmed that the above mentioned call bells were not audible. The home is currently working towards adding new sensors in the north end

of the hallway to improve the sound calibration. [s. 17. (1) (g)]

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 exhibiting altered skin integrity, including pressure ulcers or wounds 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.

Record review of resident #6's plan of care revealed the resident had a chronic wound to one of his/her legs. In the progress notes entries were made by the nursing staff on a weekly basis. The Bates-Jensen tool used for wound assessments was last completed at the end of 2012, for the resident's wound. When the charge nurse was asked why the nursing staff was no longer assessing the resident's wound he/she indicated because the wound was chronic there was no need to be assessed.

Interviews with the registered nursing staff confirmed they were no longer performing and completing the wound assessments for the resident because his/her wound was chronic and would never heal, therefore, they stopped completing the wound assessment and documented a weekly skin note instead.

Interview with the DOC confirmed even with chronic wounds they are to be assessed using a clinically approved assessment tool. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent of bowel received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review revealed that resident #007 was described as continent of bowel during the third quarterly minimum data set (MDS) assessment in 2014, and as frequently incontinent during the fourth quarterly 2014's assessment. Record review did not reveal a bowel continence assessment that includes the above mentioned components conducted between the third and fourth quarterly assessment in 2014, during which the resident had experienced a change in continence status.

Interview with an identified RPN confirmed that a bowel continence assessment was not conducted between the above mentioned periods when the resident's bowel continence status deteriorated. [s. 51. (2) (a)]

2. Record review revealed that resident #005 was described as usually continent of bowel and bladder during the third quarterly assessment in 2014, and had been unchanged for three months prior. The resident was recorded on the following quarterly assessment in 2014, as frequently incontinent of bowel with episodes of constipation and diarrhoea, and occasional incontinent of bladder. The resident was described to have deteriorated from the last assessment, and was put on a prompted voiding program. On a certain date at the beginning of 2015, the resident was recorded as frequently incontinent of bowel and bladder with scheduled toileting plan and wearing incontinent products. Record review did not reveal a continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence conducted on or after the continence status change.

Interview with an identified RN confirmed that a continence assessment was not conducted for the resident after the resident continence status changed from continent to incontinent. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Interview with the Residents`Council representative and review of the Residents' Council meeting minutes indicated that at the meeting on October 28, 2014, residents requested more cabbage on the menu, and at the meeting on December 29, 2014, residents raised the issue about the food being served cold at times. The message was passed to dietary manager and director of care.

Interview with the Residents`Council representative and the administrator confirmed that there was no written response within 10 days on the recommendations from October 28 and December 29, 2014. [s. 57. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

On January 13, 2015, on the first day of the unannounced resident quality inspection, the inspector observed during the lunch service in an identified dining room the lunch menu not being served as posted.

Staff interviews with identified staff and the dietary manager confirmed the planned menu was not offered as posted. [s. 71. (4)]

WN #9: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Interview with the Residents` Council representative and review of the Residents` Council meeting minutes for 2014 indicated that the meal and snack times were not reviewed by the Residents`Council.

Interview with the home's administrator confirmed that the meal and snack times were not reviewed by the Residents`Council. [s. 73. (1) 2.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented for cleaning of the home, including furnishings in common areas.

Observation made on January 13, 2015, at 10:20 a.m. noted three arm chairs dirty with heavy stains on the seats and arm rests in the second floor lobby area. One light color sofa chair was observed to have heavy food stains on the seat and arm rest.

Interview with an identified housekeeping aide confirmed that the chairs were not clean. The housekeeping aide stated that cleaning of the chairs in the lobby area was not his/her responsibility. However, interview with the ESM and record review indicated the housekeeping aide was responsible to clean the lobby chairs daily with a chemical Oxyclean and a cloth. The ESM stated that the upholstery of all chairs in the home was supposed to be deep cleaned using upholstery shampoo and vacuum bi-annually according to the home's policy. When asked by the inspector, the ESM was not able to present a bi-annual schedule for the deep cleaning and when the chairs were last cleaned.

Review of the home's policy titled General Cleaning Procedures - cloth Upholstery, index I.D. ES C-10-55 contains policy and procedure developed to maintain cloth upholstery in a clean and sanitary condition. Frequency of the procedure was stated as bi-annually and as required. The absence of a schedule with the required frequency of the cleaning indicated that the procedures were not implemented for cleaning of the home's chairs. [s. 87. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

Review of the training records in falls prevention and management for 2014 and interview with DOC indicated 23% of direct care staff were not provided training in falls prevention and management. [s. 221. (1) 1.]

2. The licensee has failed to ensure that training related to continence care and bowel management is provided in 2014 to all staff who provide direct care to residents.

Interview with the DOC revealed that 39% of all direct care staff did not receive continence related training in 2014. [s. 221. (1) 3.]

Issued on this 17 day of February 2015 (A1)

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

Original report signed by the inspector.