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
Oct 23, 2014	2014_348143_0018	O-000998-14	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49, R R 2, PICTON, ON, K0K-2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0

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

PAUL MILLER (143), BARBARA ROBINSON (572), JESSICA PATTISON (197)

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): October 6th-10th and October 14th-16th, 2014.

In addition Complaint Log # O-000917-14, Log # O-000703-14 and Critical Incident Log # O-001112-14 were completed as part of the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Registered Dietitian, the Office Manager, Maintenance Staff, the Environmental Manager, family members, a Family Council representative, the President of the Resident Council and residents.

During the course of the inspection, the inspector(s) Completed tours of all resident home areas, observed resident care and services, observed meal service, observed medication administration, reviewed policies and procedures and reviewed resident health care records inclusive of assessments, plan of care, physician orders and multidisciplinary care conferences.

The following Inspection Protocols were used during this inspection:

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
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that residents on the secure unit are kept safe and secure.
The following finding is in respect of a Critical Incident Log # O-001120-14.

HJ McFarland Home currently is in the process of completing a secure outdoor resident area off of the Willow Wing. The Licensee submitted renovation plans to the Ministry of Health and Long Term Care with a target date for October 1st, 2014 for project completion. On a specified date phase one of the three phase project was completed for which a barrier free access door was installed. The Environmental Manager staff (S)108 reported that the contracted company had tested the door at which time the lock was secure and was not able to be opened. On a specified date S106 inspected the door and tested it to ensure that the sliding door locked and was not able to be opened.
On a specified date Resident #15 was able to disengage the lock and eloped from the building. S107 (Personal Support Worker) reported to the Inspector that she\he had observed Resident #15 not to be present in the dining room. S107 reported that she \he called a code yellow (missing resident) and a search of the home indicated that the resident was not present in the home.
S107 reported that the resident was found off site by an Ontario Provincial Police approximately 10-15 minutes after the code Yellow was initiated. S107 reported that the resident was found out of sight and within a short distance of the homes property. The resident did not sustain any physical injuries.
The home completed repairs to the sliding door which included placing a metal plate over the locking mechanism. The door currently is locked and not able to be open. Discussions held with the Administrator who will update the Ottawa Service Area Office with a new target date for completion of the renovation project. [S. 5.]

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 increase monitoring of residents on the Willow Wing during phase two and three of the renovation project, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that plan of care gives clear direction.

The following finding is related to complaint inspection, Log #O-000703-14.

The current care plan for Resident #13 states "state of nourishment; more than body requirement. Resident #13 has lost weight and is not receiving more nourishment then required. The care plan does not provide clear directing to staff with relation to his\her nutritional status.

A review of the most recent plan of care for Resident #13 identified that the resident does not wear an incontinent product and is on a toileting program. S122 (PSW) reported to the inspector that Resident #13 wears an incontinent product and is not on a toileting program.(143) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care is provided to the resident.

The following finding is related to complaint inspection, Log #O-000703-14

HJ McFarland Home has medical directive in place in respect of bowel management. This directive identifies that a resident is to receive a laxative by mouth every 2 days as needed to stimulate a bowel movement and that a suppository is to be provided on the fourth day if the resident has not had a bowel movement.

A review of the Resident #13's specified month bowel movement record indicated that the resident did not have a bowel movement for 5 days on two occasions as well did not have a bowel movement for 6 days on one occasion.

A review of Resident #13 specified month treatment administration record (TAR) indicated that the resident did not receive a laxative every 2 days as required on 3 occasions.
The TAR indicated that Resident #13 did not receive a suppository as required every 4 days as required on 3 occasions. [S. 6. (7)]

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 residents with continence care and weight management problems have plans of care that are current, provide clear directions and that the resident receives interventions as identified within the plan of care, to be implemented voluntarily.

WN #3: 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 comply with O. Erg. 79/10, s. 8(1)(b) in that the home did not comply with their system for monitoring and evaluating the food and fluid intakes of a resident with identified risks related to nutrition.

The following finding is related to complaint inspection, Log #O-000703-14.

O. Reg. 79/10, s. 68(2)(d) states that the home's Nutrition Care and Hydration Programs must include a system to monitor and evaluate the food and fluid intakes of residents with identified risks related to nutrition and hydration.

The home's system to monitor and evaluate food and fluid intakes is electronically documenting on Point Click Care (Point of Care) resident's food and fluid intakes for nourishment's, meals and supplements.

Resident #13 is identified as being at nutritional risk, has lost weight and is currently receiving a supplement three times daily.

Upon review of Resident #13's food and supplement documentation back to a specified period following was found:

Specified month 2014
59 out of 93 nourishment intakes were not documented
72 out of 93 meal intakes were not documented
93 out of 93 supplement intakes were not documented

Specified month 2014
61 out of 90 nourishment intakes were not documented
72 out of 90 meal intakes were not documented
90 out of 90 supplement intakes were not documented

Specified month 2014
25 out of 42 nourishment intakes were not documented
31 out of 42 meal intakes were not documented
42 out of 42 supplement intakes were not documented [s. 8. (1) (a),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 That policies are followed in respect of weight monitoring and documentation in resident's nutritional intake, 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident abuse policy is complied with.

The following finding is related to a Critical Incident, Log #O-001112-14.

The Long Term Care Homes Act section 20.(2)(e) indicates that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (e) shall contain procedures for investigation and responding to alleged, suspected or witnessed abuse and neglect of residents

H.J. McFarland Memorial Home staff resource manual Resident Abuse procedure 3 indicates the following:
The Charge Nurse will fully assess the Resident following a witnessed or suspected incident of assault or abuse.

The Long Term Care Home submitted a critical incident report M556-000011-14 to the Ministry of Health and Long Term Care.
On a specified date resident #17 reported that a Personal Support Worker (S121) had been rough with him\her while providing care. S118 (RN) was informed by the Resident #17 that this staff member provides care in a rushed and aggressive manner and is not considerate. Resident #17 reported to S118 that following the care that S121 had provided, that he\she was in pain. S118 reported that the resident had reported that the incident had occurred prior to the date of his\her report.

Resident #17 was interviewed by the Inspector and reported that S121 is rough with him\her and that on the night of the incident, S121 had removed an incontinent product quickly and forcefully causing him\her to have some discomfort. Resident #17 reported that the home completed an investigation and that as an outcome S121 will no longer provide him\her care.

A review of the resident health care record indicated that no documented assessment of the resident was completed. S118 reported to the inspector that she\he had emailed a note in respect of the resident but had not documented a full assessment of the resident. S118 reported to the inspector that she\he had observed the resident in the bathroom and noted that he\her had no injury. S118 confirmed with the inspector that the resident did complain of pain. A review of the resident health record indicated that the resident requested and was provided an analgesic on a specified date. The Administrator reported to Inspector #143 on October 16th that a documented assessment on the resident health care record would be required following an incident

of suspected or alleged abuse.
There was no evidence to support that the home had fully assessed the resident following the incident of suspected abuse. [s. 20. (1)]

2. The licensee has failed to ensure that the abuse policy clearly set out what constitutes abuse and neglect,
HJ McFarland's abuse policy identifies and provided examples of abuse. The homes abuse policy does not identify that physical abuse is the use of physical force by anyone other then a resident that causes physical injury or pain. Physical abuse as per Ontario Regulation 79/10 section 2. (2) identifies that physical abuse does not include the use of force that is appropriate to the provision of care or assisting residents with activities of daily living, unless the force used is excessive in the circumstances.
HJ McFarland's abuse policy does not clearly define what abuse is. [s. 20. (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 the policy is complied with in respect of monitoring a resident following an alleged abuse incident in addition the home must ensure that the Zero Tolerance Abuse Policy clearly defines what constitutes abuse as per Ontario Regulation 79/10 section 2(1) abuse definition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 37(1)(a) in that personal items were not labelled within 48 hours of admission and of acquiring, in the case of new items.

During stage 1 of the Resident Quality Inspection (October 6-8, 2014) the following was observed:

Two resident rooms had -unlabelled combs on sink in resident's shared bathroom
2nd floor tub room - 3 unlabelled black combs with hair in them, 6 unlabelled and dirty nail clippers, 1 container of Vitarub, open and unlabelled
2nd floor shower room (#245) - open and unlabelled containers of Vitarub and Zinc cream, 2 pairs of unlabelled and dirty nail clippers, 2 unlabelled brushes with hair in them and 1 unlabelled comb
1st floor Willow Wing tub room - unlabelled zinc cream - open and used, two unlabelled and used deodorants, unlabelled urinal on floor
1st floor Lilac Lane shower room - 3 pairs of used/dirty nail clippers in 1st drawer of storage bin, 1 unlabelled brush on hot water heater, 1 unlabelled and used brush on shelf, bar of soap left in shower not in labelled container [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that all resident personal items and personal aids are labelled, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that a 7.5% weight loss and two 10% weight losses for a residents were not assessed using an interdisciplinary approach.

The following finding is related to complaint inspection, Log #O-000703-14.

Resident #13 is assessed as being at nutritional risk, is on a mechanically altered diet and currently receives a supplement with meals. This resident has lost weight.

The Resident's weight changes and relevant nutritional assessments were reviewed. It was noted during this review that there were no assessments related to Resident #13's 7.5% and 10% weight losses that triggered weight warnings for two specified months.

The home's Weight Change policy was reviewed and states that a referral will be made to the Registered Dietitian for residents with unplanned weight loss within the above parameters (5%, 7.5%, 10%). It then states that the Registered Dietitian will conduct a thorough assessment of Residents referred and investigate possible nutrition factors responsible for the weight change.

The Manager of Nutritional Services, staff member #S108, stated in an interview on October 15, 2014 that weight assessments would be completed within the month that the weight warning occurred.

In a phone interview with the Registered Dietitian on October 15, 2014, she confirmed that she did not assess weight losses for Resident #13 for two identified months. She further stated that if she had completed them they would have been done within the month that the weight warnings had occurred. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 all residents with significant weight lost are assessed using an interdisciplinary approach, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 21 in that the temperature in the home was not always maintained at a minimum of 22 degrees Celsius.

During stage 1 of the Resident Quality Inspection (October 6-8, 2014) the following was reported to inspectors:
- Resident #11 stated that she finds the home too cold.
- Resident #19 stated that he finds the hallways and dining room are too cold. He stated he has reported the issue but it has not yet been addressed.

During an interview with staff member #S106, he stated that he monitors the temperatures and thermostats in the home daily and records these temperatures in a log. The Daily Wing/Floor Temperatures sheets from July to September were reviewed and the following was noted:
On September 15th the Willow Wing had a recorded temperature of 20.3 degrees Celcius and 20.6 degrees Celcius on September 16th. [s. 21.]

WN #8: 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 comply with O. Reg. 79/10, s. 27(1) in that annual care conferences were not held and if they were, a record was not always kept for a particular resident.

The following finding is in relation to complaint inspection, Log #O-000703-14.

Resident #13's Substitute Decision Maker (SDM) indicated to Inspectors that the resident has been in the home for several years and she\he had only been to two annual care conferences.

Upon review of Resident #13's health care record the following was noted:
- Two care conferences were held in 2014 and a record was kept
- A care conference was scheduled for the resident Nov 5, 2013 and December 12, 2013. On the schedule both were crossed out and beside the December 12, 2013 date it stated "could not reach". No record was kept of the participants or the results of the care conference in 2013
- A care conference assessment was opened dated September 12, 2012, but only the life enrichment section was completed. No record was kept of the participants or the results of the care conference in 2012.
- No records could be found related to a care conference in 2011

During a telephone interview with the Administrator of the home on October 17, 2014, she stated the following:
- 2013 care conference - she stated that the home did have a care conference but a record was not kept
- 2012 care conference - she confirmed that there was no care conference that year
- 2011 care conference - she would not be able to find record of the conference since there was a different Director of Care at that time [s. 27. (1)]

WN #9: 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 failed to comply with O. Reg. 79/10, s.50 (2)(b)(iv) whereby the licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
The quarterly skin assessment for a specified date for Resident #9 states that the resident has an ulcer A review of the resident health care record indicated a skin assessment was completed on a specified date assessing the ulcer. This ulcer was next assessed seventeen days later. S102 (RPN) confirmed with Inspector #143 on October 22, 2014 that Resident #9 did not have a weekly skin assessment as required. [s. 50. (2) (b) (iv)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.109 (e) whereby the licensee did not ensure that the home's written policy, in accordance with LTCHA 2007, c.8, s.29, deals with how consent to the use of physical devices for restraint is to be obtained and documented.

On October 16, 2014 the DOC provided the home's current policy "HJ McFarland Memorial Least Restraint Policy". The policy states that informed consent is required for the use of a restraint. In addition, the "Physical Restraint/PASD Information Sheet", provides a space for resident and nurse signatures as well as the date.
In an interview on October 16, 2014, the DOC and Administrator acknowledged that the policy does not specify how informed consent is to be obtained and documented, and that the information sheet would not be considered the home's consent form. The DOC stated that policies are being updated and switched to electronic format so some information has not yet been updated. The Administrator stated that this policy will be linked with an informed consent policy to provide consistent documentation.
The home's written policy does not describe how consent to the use of physical devices for restraint is to be obtained and documented. [s. 109. (e)]

WN #11: 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 comply with O. Reg. 79/10, s. 229 (4) in that staff do not participate in the implementation of the infection prevention and control program by not cleaning nail clippers.

The Nail Care policy RC-50 was reviewed and step 7 of the procedure states that following use, non disposable items are to be soaked in alcohol for 15 minutes and then rinsed with water and dried. Each resident is to have their own nail clippers.

During the initial tour of the home the following was observed:
1st floor shower room on Lilac Lane - 3 pairs of unlabelled, dirty nail clippers in 1st drawer of storage bin
2nd floor tub room - 6 unlabelled, dirty nail clippers in cart
2nd floor shower room (# 245) - 2 pairs of unlabelled, dirty nail clippers [s. 229. (4)]

Issued on this 23rd day of October, 2014

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