Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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 9, 2014	2014_271532_0032	L-001222-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
959 9th Avenue East, OWEN SOUND, ON, N4K-3E3

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

ROCKWOOD TERRACE HOME FOR THE AGED
575 SADDLER STREET EAST, P. O. BOX 660, DURHAM, ON, N0G-1R0

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

NUZHAT UDDIN (532), DEBORA SAVILLE (192), SHERRI GROULX (519)

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): September 23, 24, 25, 26, 29, 30 and October 1, 2, 2014

Concurrent CIS was completed: #002337-14

During the course of the inspection, the inspector(s) spoke with the Executive Director , Director of Care (DOC), Resident Care Coordinator (RCC), Environmental Manager, Resident and Family Service Program Manager, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance staff, Family and Resident Council Representatives, Residents and Family members.

During the course of the inspection, the inspector(s) toured the resident home areas and common areas, medication rooms, the kitchen, the servery, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of the residents were fully respected and promoted:every resident has the right not to be neglected by the licensee or staff.

A) Record review indicated that an identified resident was assisted on the toilet for an unidentified period of time.

Record review revealed that the oncoming staff were not advised that the resident was sitting on the toilet.

Record review further revealed that the oncoming staff when making rounds discovered the resident on the toilet.

Interview with the Director of Care confirmed that the resident was left on the toilet for an unidentified period of time and the rights of the resident not to be neglected was not respected. [s. 3. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of the residents are fully respected and promoted:every resident has the right not to be neglected by the licensee or staff, 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A) The plan of care related to risk for falls for an identified resident stated that the resident was to have a rail up for assistance when in bed.

The plan of care indicated the resident required the use of rails.

Interview with the Personal Support Worker and Registered Nurse identified a discrepancy in their understanding of the care that the resident required.

Interview with the Registered Practical Nurse confirmed that there was a conflict in the plan of care and that the plan of care did not provide clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

A) An identified resident had a fall.

Record review revealed that the resident was at risk for falls and there were no interventions listed in the plan of care related to footwear as a safety risk.

Upon interview with the Director of Care (DOC) it was confirmed that the plan of care should have been revised, and when the resident was identified as a moderate fall risk, the interventions related to the fall should have been identified on the plan of care. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, 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 ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy, or system was complied with.

A) Policy on Zero Lift indicated that "all transfers with lifts or transfer devices, i.e. Hoyer, tub, lifts, will be conducted by a minimum of two staff. Residents will not be left unattended in a mechanical lift at any time."

Record review stated that an identified resident was discovered alone and attached to the lift.

Review of the plan of care stated that the resident required assistance with the mechanical lift.

An interview with the DOC confirmed that the staff did not comply with the policy and confirmed that the expectation was not to leave the resident unattended in a mechanical lift at any time. (532)

B) According to a Painting policy stated that "quarterly checks will be completed to ensure all walls, ceilings, doors and frames are free of marks, scrapes, and chips". The procedure stated that quarterly the Building Services Manager or designate will check the following:

1. Inspect all resident rooms, dining rooms, common rooms, hallways, etc for wall repairs and painting repairs.

2. Touch up plaster and paint in all required areas.

3. Maintain a record of painting.

Observations made during stage 1 of the Resident Quality Inspection (RQI), of resident's rooms and general environment of the home revealed that there were several areas of the home that required painting and repairs.

Resident home areas were verified as needing repair and painting by the Environmental/Building Manager during the tour with the inspector.

The Environmental/Building Manager confirmed that there was no painting schedule to show the preventative maintenance of the areas requiring repair.

It was also confirmed that there were no recent resident room audits to show preventative maintenance of the repair required in the resident rooms.

C) Policy titled Mechanical Lifts stated that "Scheduled preventative maintenance checks will be completed to verify the correct and safe operation of Mechanical Lifts". The procedure states that the Building Services Supervisor or designate will:

1. Follow specific manufacturer’s preventative maintenance requirements for their lifts.

2. Complete the bi-monthly checklist and file in the maintenance audit binder.

3. Ensure the annual preventative check is completed as well as the annual Load Test by an external service provider.

During an interview with the Environmental/Building Manager it was revealed that the lifts were repaired when notified by nursing staff that they needed to be repaired.

It was also confirmed that regular audits for maintenance of the Resident Mechanical Lifts were not being done.

The Environmental/Building Manager was not able to provide regular audits of Mechanical Lift Preventative Maintenance.

The plan, policy, protocol, procedure, strategy, or system was not complied with, as the resident room audits, the record of the painting schedule, and the bi-monthly checklists for Mechanical Lifts could not be provided. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 is complied with, to be implemented voluntarily.

WN #4: 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 has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) Following observation was made in Stage 1 of the Resident Quality Inspection (RQI), it was noted that there were areas of the home and equipment that were not kept in a good state of repair.

In the bathrooms of an identified rooms, the toilet safety handle was broken and lying on the floor.

The identified room still had the safety handle broken on the right side but it was no longer on the floor.

An identified room had the safety handle broken on the left side and it was lying on the floor under the sink.

The above observation were confirmed during a tour of these two rooms with the Environmental/Building Manager.

B) During the tour with Environmental/Building Manager it was confirmed that the following areas needed repair:

In an identified room - chipped paint noted on the metal door trim on the bathroom door and doorway.

In an identified room - chipped paint noted on the metal door frames, bathroom and bedroom walls.

In an identified room - bathroom door was scratched and the protector guard was off, holes noted on the bathroom wall, and the caulking was peeling around the toilet.

In an identified room - broken bathroom door edge and broken wall protector by the bathroom.

In an identified room - chipped paint along the edges of the wall in the bathroom and scratch marks noted on the bathroom wall.

In an identified room - holes noted on the bathroom wall, a missing towel holder was observed and the toilet safety handle was missing on the right side.

In an identified room - broken base board was noted and scratched up wall was noted at the entrance to the room.

In an identified room - the drywall was chipped off on the edges of the wall by the closet and scratch marks noted on the wall.

In an identified room - there were scratched up broken tiles at the entrance to the

room.

The above observation were confirmed during a tour of the rooms with the Environmental/Building Manager and it was confirmed that there were no audits past April 24, 2104 to show the maintenance of the repairs required in the resident's room. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) An identified resident was observed with a side rail in up position.

Director of Care confirmed that bed entrapment risk assessment was initiated on new admissions and was to be completed on all residents by the end of the quarter; however, the identified resident was not assessed for bed rails in accordance with evidence-based practices.(532)

B) It was observed during Stage 2 of the RQI that an identified resident had rails raised near the head of the bed.

Upon interview with the Director of Care (DOC) it was revealed that the home implemented a new Bed Entrapment Assessment on Point Click Care. The DOC explained that the side rail assessment was included with the Bed Entrapment Assessment and the plan was to complete the assessment on new admissions for now and all other residents would be assessed by the end of the next quarter.

During this interview it was confirmed by the DOC that the identified resident was not assessed for bed rails. [s. 15. (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 to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: 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 resident #008 who was exhibiting altered skin integrity, including skin breakdown and pressure ulcers, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) An identified resident was noted to have altered skin integrity. No initial date of assessment could be identified.

Record review revealed that the altered skin integrity was not assessed during an identified time frame.

Record review and interview with the Registered Practical Nurse confirmed that weekly skin assessments from the time the altered skin integrity was identified were not completed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who are exhibiting altered skin integrity, including skin breakdown and pressure ulcers, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #7: 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 was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A) Record review for an identified resident stated that they were incontinent of urine.

During stage 1 of the Resident Quality inspection it was noted that the identified resident was observed wearing soiled pants.

A Personal Support Worker reported that resident was toileted routinely throughout the day but leaked at times with the product.

In an interview the Director of Care confirmed that there was no assessment for incontinence and that the resident was not assessed. [s. 51. (2) (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 to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 86. Accommodation services programs

Specifically failed to comply with the following:

s. 86. (2) Where services under any of the programs are provided by a service provider who is not an employee of the licensee, the licensee shall ensure that there is in place a written agreement with the service provider that sets out the service expectations. O. Reg. 79/10, s. 86 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where accommodation services are provided by a service provider who is not an employee of the licensee, the licensee has a written agreement with the service provider for maintenance services that sets out the service expectations.

A) During an interview with the Environmental/Building Manager it was confirmed that there was no written agreement with the company that provided the services for the Heating Ventilation and Air Conditioning System, and the commercial restaurant company that provided services for the repair of the kitchen equipment.

The Administrator also confirmed that the there was no written agreement with the above service providers who were not employees of the home. [s. 86. (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 where accommodation services are provided by a service provider who is not an employee of the licensee, the licensee has a written agreement with the service provider for maintenance services that sets out the service expectations, to be implemented voluntarily.

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 has failed to ensure that drugs were stored in an area or a medication cart,
iv. that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

A) During the observation of the medication room it was noted that there were expired medications in the cupboard used to store inhalation medication.

In an interview a Registered Practical Nurse (RPN) confirmed that the medications were expired.

The RPN confirmed that the drugs were not to be stored on the medication shelf or in the medication fridge if they were expired. [s. 129. (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 to ensure that drugs were stored in an area or a medication cart,
that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting)., to be implemented voluntarily.

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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

A) Following observations were made during stage 1 of the Resident Quality Inspection(RQI):

In an identified room there was an unlabeled slipper bed pan beside the toilet on the floor.

In an identified room there was an unlabeled urine collection hat on the floor beside the toilet and an unlabeled catheter bag hanging on the towel bar.

During observation of the medication room it was noted that there was a box of Med Plus 2.0 open and sitting on top of the medication cart, half full and not refrigerated. (519)

B) Following observations were made during stage 1 of the Resident Quality Inspection:

In an identified room - unlabeled items were noted i.e. cream, soap dish, basin and pink ware sitting on the floor in the shared bathroom.

In an identified room - unlabeled hairbrush was observed and the bathroom was used by two residents.

In an identified room - an unlabeled denture cup was noted in the bathroom and an empty unlabeled catheter bag hanging on a towel hanger.

In an identified room - an unlabeled urinal was hanging on a towel holder.

In an identified room - an unlabeled comb was sitting on the toilet tank and the

bathroom was shared by two residents. A Personal Support Worker reported that this was left on the toilet after morning care but the expectation was that it should be stored away after appropriately.

In an identified room - an unlabeled toothbrush in a cabinet upside down on top of a nail filer and an unlabeled dirty soap dish was sitting in the same cabinet.

In an identified room - an unlabeled catheter bag was hanging on a towel bar in a shared bathroom and a urinal sitting on bedside table.

In room an identified room - an unlabeled blue denture cup was noted in the bathroom that was shared by two residents, nail clipper and comb with hair noted sitting on the night stand.

Director of Care confirmed that all items should be cleaned, labeled and stored in resident shelf in the bathroom.

A staff member was observed getting on the elevator from a home area with gloves on and was observed going into the kitchen with the same gloves.

A staff member was observed coming out of an identified room with gloves on, observed using the key pad to go down stairs, and later observed the same staff walking back in the room with gloves on to work on the plumbing in the bathroom.

The staff member confirmed that the expectation was to take gloves off before he left the room but did not.

Another staff member was observed wearing gloves in the hallway.

Director of Care confirmed that the staff were educated on hand hygiene and confirmed that gloves were to be removed when the task was completed and not to be worn out in the hallway.(532)

C) Following observations were made during stage 1 of the Resident Quality Inspection:

In the shared bathroom an identified room, it was observed that a soiled, unlabeled catheter bag was hanging over the towel bar. The towel bar was labeled with a

resident name, but not the name of either resident in the room.

In the shared bathroom in an identified room, a pink unlabeled bedpan and an unlabeled urinal were noted sitting on the floor.

It was observed again that an unlabeled catheter bag was hanging on the towel bar in the shared bathroom in an identified room.

Staff interviewed identified that the catheter bag was used by a resident of the room and was routinely stored on the towel bar where it was accessible to the other resident in the room. The used bedpan and urinal remained on the floor in the bathroom.

The licensee failed to participate in the implementation of the infection prevention and control program when pink ware was stored on the floor in the bathroom and when the integrity of the catheter bag was potentially jeopardized when it was left unlabeled on the towel bar in the shared bathroom. In addition, the co-residents in the shared rooms were at risk should they handle the soiled catheter bag. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language.

A) A clinical note for an identified resident indicated that staff had communication issues.

A Registered Practical Nurse (RPN) in an interview reported that resident had communication problems.

In an interview a Registered Practical Nurse confirmed that the plan of care should have been started on communication after it was triggered through Minimum Data System; however, there was no plan of care developed based on the interdisciplinary assessment of the resident's communication abilities. [s. 26. (3) 3.]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's skin condition.

A) A Registered Practical Nurse reported that an identified resident did not have any skin issues and the skin was intact.

Record review stated an initial Skin and Wound Care Assessment Summary was completed and it indicated that the resident had altered skin integrity.

Interview with the Director of Care (DOC) confirmed that the wound was being monitored by the registered staff as it was documented on the Treatment Administration Record. However, care plan, which was accessible to all staff did not include focus, goals and interventions. [s. 26. (3) 15.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Restraint Management policy is complied with.

A) The home's policy titled Restraint Management Protocols indicated that Personal Support Workers (PSW) are responsible to: 7. Document every hour on the restraint monitoring record, the resident's response, position and the PSW's actions while the restraint is applied.

Record review and interview confirmed that PSW's were not documenting hourly for an identified resident.

A record review revealed that documentation for observation and repositioning was not completed hourly.

Interview with the Director of Care confirmed that all staff had been educated on the expectation to record their observations and repositioning of residents in restraints hourly in Point of Care. [s. 29. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

A) The home had commenced an investigation related to an identified resident.

Record review indicated that the investigation was completed.

The Administrator confirmed that the resident’s SDM was not notified of the results of the investigation immediately upon the completion. [s. 97. (2)]

Issued on this 14th day of October, 2014

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