Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 20, 2014	2014_257518_0031	L-000674-14	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4

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

TILBURY MANOR NURSING HOME
16 FORT STREET, P.O. BOX 160, TILBURY, ON, N0P-2L0

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

ALISON FALKINGHAM (518), ALICIA MARLATT (590), ROCHELLE SPICER (516)

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): June 16, 17, 18 19, 20, 24, and 25, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, The Acting Director of Care, The Environmental Services Supervisor, Dietary and Kitchen Staff, Registered Staff and Personal Support Workers, family members and residents.

During the course of the inspection, the inspector(s) reviewed residents clinical records, the homes policies and procedures, observed general and specific resident care, observed medication administration and several meal services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

A resident has a care plan which indicates that the residents weight is to be monitored monthly.
Review of this resident's record revealed no weight documentation for the following months: April 2014, January 2014, October 2013, August 2013 and July 2013.

The Administrator confirmed that it is the Homes expectation that care is provided to residents as outlined in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A resident's care plan indicates they are to have one half rail raised at all times.
Two of three staff members interviewed were unaware of the contents of the care plan regarding side rails.

The Administrator confirms it is the expectation that all staff are aware of the contents of the plan of care which is available on paper at the nursing desk in a separate binder. [s. 6. (8)]

3. The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

During staff interviews on June 26, 2014 two of three staff interviewed were unable to identify the continence status of a resident.

The Acting Director of Care confirms that it is the expectation that all staff are aware of the contents of the care plan which is available on paper at the nursing desk in a binder. [s. 6. (8)]

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 relating to providing clear directions in the plan of care and ensuring staff are kept aware of its contents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy regarding medication self administration was complied with.

Medical Pharmacies Long Term Care Services
Section 5
Handling of Medication
Policy 5-5
Self Administration of Medications
-are permitted when specifically ordered by a physician
-resident must be deemed capable
-the medication must be stored in a secure place inaccessible to other residents
-a self administration assessment form must be completed and filed with the MAR
-physician must write orders that the resident may self administer
-the nurse is not required to document the administration on the MAR
-documentation of the counselling between the physician and resident about the medication must be in the progress notes
-Resident must sign a resident self administration agreement and it must be filed on

the chart
-a self administration assessment form must be completed quarterly
-must be documented in the care plan
-weekly progress notes should indicate the residents ongoing compliance

A resident has a prescription cream in their room that they apply to them self twice daily with no documented physician order, no progress notes documenting this, no self medication agreement or assessments on the chart.

The Acting Director of care confirms that it is the homes expectation that the policies in place be followed. [s. 8. (1)]

2. The licensee did not ensure that any policy and procedure instituted or otherwise put in place was complied with.

A resident was hospitalized. The homes policy "Hospital Transfer", policy number NM-II-H025, page 3, procedure "Re-admission from Hospital" states:

"The RN/RPN will: hold a short interdisciplinary conference after 72 hours to discuss changes and modify care plan".

The inspector was unable to locate documentation to verify an interdisciplinary conference was held after 72 hours upon the residents readmission from hospital.

The RAI Coordinator/Acting Director of Care confirmed that an interdisciplinary conference was not held as per the homes policy and procedure. [s. 8. (1)]

3. The licensee did not ensure that any policy and procedure instituted or otherwise put in place was complied with.

The homes current policy for "Fall Prevention and Management", policy number NM-II-F005, page 3, procedure for "Management of a Fall Incident" states:

"Implement head injury routine if trauma to the head was suspected, or if the resident is on anti-coagulant therapy, or if it was an unwitnessed fall".

A resident's health care record revealed an unwitnessed fall. This fall was confirmed by the RAI Coordinator/Acting Director of Care. The inspector was unable to verify in

the residents health care record that a head injury routine was completed after this unwitnessed fall.

A resident's health care record revealed an unwitnessed fall. This fall was confirmed by the RAI Coordinator/Acting Director of Care. The inspector was unable to verify in the residents health care record that a head injury routine was completed after this unwitnessed fall.

The RAI Coordinator/Acting Director of Care further confirmed that a head injury routine was not completed for the residents after these falls. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee failed to ensure that pain management policy was complied with.

The Pain Management Policy
NM-11-P010
revised February 2009 indicates,
-reassess the resident weekly when the resident is receiving medication for pain using form 079 Pain Flow Record
-consider non pharmacological interventions
-the RN will evaluate the patients response to medication
-document response to analgesia given in the MARS or progress notes

There are no weekly assessments for three reviewed residents on routine or as needed analgesia, no documentation of effectiveness for routine analgesics and no documentation of non pharmacological interventions.

The Acting Director of Care confirms it is the expectation that the homes policies be followed. [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 relating to following Policies and Procedures of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home is kept clean and sanitary.

The home went into outbreak during this RQI. Swabs done by Public Health revealed Rhino virus.
Housekeeping is available 7 days a week 7am-3pm.
During the second week of the outbreak an additional housekeeper was brought in from 4pm-8pm

During observations on the first floor June 16, 17, 24 and 25, 2014
room 112 brown matter on toilet tank in shared bathroom
room 110 brown matter on toilet rim
room 107 brown stain on bowl tank and seat of shared washroom
1st floor findings confirmed by an RN

During observations on the second floor June 16, 17, 24 and 25, 2014
2nd floor shared washroom across from room 217 dried and wet brown matter stains to inner edge of raised toilet seat
room 220 brown stain to curtain
room 220 shared washroom had white dried stains to mirror and towel dispenser and urine collection container on the back of the toilet tank has dried crusted brown material on its exterior
room 211a brown dried stain to inner rim of raised toilet seat
room 208 stains on curtain between beds a and b
room 207d blue stain on curtain
second floor findings confirmed by an RPN

The Administrator/Environmental Services Manager confirms it is the expectation that the home be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure the homes equipment, specifically the dining room coffee mugs used by the residents, were kept clean and sanitary.

On June 26, 2014, the coffee mugs in the first floor dining room were inspected for cleanliness. A Personal Support Worker confirmed the coffee mugs on the dining tables should be clean and ready for residents to use at lunch. The coffee mugs were placed on the dining tables upside down. The Personal Support Worker turned each mug over for the inspector to view. 10/19 (53%) of the coffee mugs on the tables had dried food residue and/or staining on the inside of the mug.

These coffee mugs were viewed by the RAI Coordinator/Acting Administrator and the Food Service Manager who confirmed the coffee mugs did not meet the homes policy and expectations of cleanliness. [s. 15. (2) (a)]

3. The Licensee has failed to ensure the homes equipment, specifically the dish machine, was maintained in a good state of repair.

The homes "Dish Machine Temperature Record" states the acceptable temperature for the wash cycle was 60 – 71 degrees Celsius and the rinse temperature was minimum 60 degrees Celsius (140 degrees Fahrenheit).

Review of the homes completed Dish Machine Temperature Record for April 2014 revealed there were 51/175 (29%) of documented temperatures that were below the acceptable temperatures. Review of the homes completed Dish Machine Temperature Record for May 2014 revealed there were 74/180 (41%) of documented temperatures that were below the acceptable temperatures.
Review of the homes completed Dish Machine Temperature Record for June 2014 revealed there were 54/154 (35%) of documented temperatures that were below the acceptable temperatures.

The homes provider of commercial cleaning, sanitation and hygiene solutions is Diversey. A letter from Diversey's Territory Manager, dated February 03, 2014, revealed the home was provided with a quote for a "Temp-sure Booster" for Tilbury Manor. This letter states that; "on my last visit we discussed the option of using a booster to increase the temperature to the dish machine to 140 degrees. This is the

temperature required to achieve proper sanitation in the dish machine".

The Administrator and Food Service Manager confirmed these findings including receipt of the quote letter and that the home planned to install a temperature booster but has not yet done so. [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 regarding keeping the home clean and sanitary through an organized system of housekeeping, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure the homes Skin and Wound Care program had relevant policies, procedures and protocols.

The Inspectors requested to view the homes skin and wound care policies during the inspection. The Administrator provided policy number NM-II-SO10, Skin Care; policy number NM-W020, Wound Care and policy number NM-II-SO35, Surgical Wounds.

The homes policy titled "Skin Care", policy number NM-II-SO10, stated this policy was based on the 2005 Ministry of Health and Long Term Care Standards on skin care. The most recent Ministry of Health and Long Term Care skin and wound care

standards (regulations) came in to effect in June 2010. This policy was viewed by the Administrator and RAI Co-ordinator/Acting Director of Care. The Administrator and RAI Co-ordinator/Acting Director of Care confirmed this policy was the policy currently in effect at the home. In addition to this, the requirement for; at least weekly reassessments by a member of the registered nursing staff, if clinically indicated when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not listed in any of the skin and wound care policies provided. The requirement for at least weekly re-assessments came into effect in June 2010, as part of the Ontario Regulations 79/10 General. [s. 30. (1) 1.]

2. The licensee has failed to keep an annual written record for the years 2010, 2011, 2012 and 2013 relating to evaluation of all the required programs (Falls Prevention and Management, Skin and Wound Care, Continence and Bowel Management and Pain Management) 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 those changes were implemented.

This was confirmed by the Administrator on June 27, 2014. [s. 30. (1) 4.]

3. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A resident has a wound which requires dressing changes every three days and an assessment every week.
Record review for this resident during the time period of January 1, 2014 through to June 20, 2014 revealed documented wound assessments on 6 of the 24 weeks.

The RAI coordinator confirmed that it is the Homes expectation that wound assessments are completed and documented every week. [s. 30. (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 for each of the interdisciplinary programs, there are relevant policies and procedures and that they are evaluated and updated annually, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

A resident's health record revealed that a "red, non-blancheable spot was noted on right ischeal tuberosity" and that on April 16, 2014, the "ulcer to right ischium tuberosity was healed." The residents "Screening for Nutritional Risk" documentation was reviewed. This documentation revealed the Registered Dietitian completed assessments on November 26, 2013, February 14, 2014 and April 21, 2014. The inspector was unable to locate a Registered Dietitian assessment/re-assessment for the ulcer which began on March 02, 2014.

This was confirmed by the RAI Coordinator/Acting Administrator. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.
A resident's health record revealed that on March 02, 2014, a "red, non-blancheable spot was noted on right ischeal tuberosity" and that on April 16, 2014, the "ulcer to right ischium tuberosity was healed" with no weekly documentation in between.

The Acting Director of Care confirms that the weekly wound assessments were not completed and documented. [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 regarding the assessment and documentation of wounds according to their policies, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff of the home complied with policies and procedures for the safe operation and cleaning of equipment related to the food production system specifically related to the operation of the dish machine.

On June 27, 2014, the Food Service Manager confirmed the homes policy and procedure for documenting concerns related to the dish machine temperature and remedial action for temperatures below acceptable levels was "staff are to document what remedial action was taken when the dish machine temperature was below the acceptable level in the 'operating comments' on the homes 'dish machine temperature record'. The Food Service Manager reported the expectation was that staff would wait until the dish machine reached the acceptable temperature before using it and that this should be noted on the dish machine temperature form. The homes "Dish Machine Temperature Record" states the acceptable temperature for the wash cycle was 60 – 71 degrees Celsius and the rinse temperature was minimum 60 degrees Celsius (140 degrees Fahrenheit). Review of the homes completed Dish Machine Temperature Record for April 2014 revealed there were 51/175 (29%) of documented temperatures that were below the acceptable temperatures. Review of the homes completed Dish Machine Temperature Record for May 2014 revealed there were 74/180 (41%) of documented temperatures that were below the acceptable temperatures. Review of the homes completed Dish Machine Temperature Record for June 2014 revealed there were 54/154 (35%) of documented temperatures that were below the acceptable temperatures.

The Food Service Manager and Administrator confirmed the operating comments including remedial actions, had not been documented for any of the occasions when the dish machine was noted to be below the acceptable temperature range during the months of April, May and June 2014. The Food Service Manager and Administrator further confirmed they were unable to verify that the staff had waited until the dish machine reached the acceptable temperature range prior to using it, in part, due to the operating comments and remedial actions not being recorded on the dish machine temperature record. [s. 72. (7) (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 regarding safe operation of equipment, specifically the dish machine, in food service production, to be implemented voluntarily.

WN #7: 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:
3. Continence care and bowel 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:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to the residents were provided training related to continence care and bowel management on an annual basis.

The Administrator confirmed that only 50/62 staff (81%) were provided training related to continence care and bowel management in 2013. [s. 221. (1) 3.]

2. The licensee failed to provide training to all staff who provide direct care to residents in pain management including, pain recognition of specific and non specific sign of pain.

Diversicare provides a computerized program called TIDE which is done annually by all staff however it does not include any training in pain identification or management. There is no documentation of any in services regarding pain.
This is confirmed by RPN Pain/Palliative Care Leader

The Acting Director of Care confirms it is the expectation that all staff be educated in pain identification and management. [s. 221. (1) 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 regarding additional training for all staff in pain recognition and management and continence care and bowel management, to be implemented voluntarily.

WN #8: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

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

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection control program.

A resident was using the commode for a BM June 19, 2014 at 1330.
At 1430 on June 19, 2014 the residents washroom had lingering odour and the

commode had feces staining on the sides. On further observation the raised toilet seat, toilet tank and lid also had feces adhered to it.

The Administrator confirmed it is her expectation that staff clean commodes properly and participate in the infection control program. [s. 229. (4)]

2. The licensee has failed to ensure that each resident admitted to the home screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

A resident was admitted to the Home . The process for screening for TB has not been initiated to this date for this resident. A Registered Practical Nurse confirmed that the TB screening process should have been completed at this time. A resident was admitted to the Home on May 5, 2014. To this date the resident has had only step one completed. A Registered Practical Nurse confirmed that the TB screening process should have been completed at this time.
The Acting Director of care confirms the homes expectation is to have all new admissions tested for TB. [s. 229. (10) 1.]

3. The licensee has failed to ensure that residents offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A Registered Practical Nurse confirmed that the Home has not offered pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website to their residents.

The Acting Director of Care confirms it is the expectation of the home that publicly funded immunizations be offered to residents. [s. 229. (10) 3.]

4. The licensee failed to ensure that all pets living in the home or visiting as part of a pet visitation program have up-to-date immunizations.

Record review of a regularly visiting dog revealed immunizations are over due for DAZPP and Rabies.
A Registered Practical Nurse confirmed that it is the homes expectation that all visiting pets have up to date immunizations.

The Acting Director of care confirms all pets visiting this facility have their annual vaccines. [s. 229. (12)]

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 regarding annual evaluations of the infection control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

On June 16 2014 Inspector # 590 found an unlocked spa room door which contained Virex 256 disinfectant chemical. A Registered Practical Nurse confirmed that it is the homes expectation that all spa rooms are locked when not in use and locked the door. On June 16 2014 Inspector # 590 found an unlocked housekeeping room which contained Virex 256 disinfectant cleaner and Stride HC natural cleaner and cleaning equipment. A Registered Practical Nurse confirmed that the housekeeping doors should be locked and inaccessible to residents at all times and locked the door.

The Acting Director of Care confirms the expectation is that all housekeeping doors be locked to ensure hazardous substances are kept inaccessible to residents. [s. 91.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On June 20 and 24, 2014 the first floor medication storage area was observed and the refrigerator which contained insulin, other oral and injectable drugs as well as isosource for tube feeds did not have a thermometer or a log book to document daily temperatures.

The Director of Care, the Administrator and the Charge Registered Nurse confirmed it is their expectation that the refrigerator should have a thermometer inside, that there should be a log book and that daily temperatures should be documented. [s. 129. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131(5)

A resident was observed to have a jar of prescription cream at their bedside and states that they applies it to them self twice daily.
There is no documentation on the MAR or physician order sheet that this resident may self administer medication.

The Acting Director of Care confirms that is the expectation that self administered medications be ordered by a physician and documented on the MAR. [s. 131. (5)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure a written record was maintained for each resident of the home.

On June 26, 2014, the RAI Coordinator/Acting Director of Care and a Registered Practical Nurse confirmed that a treatment administration record is developed for documenting skin and wound care. The RAI Coordinator/Acting Director of Care and Registered Practical Nurse confirmed that the treatment administration record may be recorded on the homes medication administration record.

The inspector requested to view the treatment administration record for skin and wound care for a resident from March 02, 2014 until April 16, 2014. The RAI Coordinator/Acting Director of Care provided the inspector with two treatment/medication administration forms. Both records did not have the date and year written on the record and the RAI Coordinator and Registered Practical Nurse were unable to confirm the month and year these records were created.

The RAI Coordinator/Acting Director of Care confirmed the homes expectation that all resident records should be maintained with the inclusion of the month and year documented on the form. [s. 231. (a)]

Issued on this 20th day of August, 2014

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