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
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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 29, 2014	2014_157210_0012	T-066-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - VAUGHAN
5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1

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

SLAVICA VUCKO (210), MATTHEW CHIU (565), NITAL SHETH (500), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 8, 9, 10, 11, 14, 15, 16, 17,18, 21, 22, 23, 2014.

Additional inspections related to the following log#'s were also completed during this inspection:
Log # T-104-13 related to the CIS # 2945-00008-13
Log # T-203-14 related to the complaint IL-31186-TO
Log # T-293-14 related to the complaint CIS/IL 2945-00006-14 and 2945-000074-13
Log # T-593-13 linked with T-678-13 related to CIS 2945-000070-13.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), director of nursing (DON), assistant director of nursing (ADON), nurse managers (NM), registered nurses (RN), registered practical nurses (RPN), behavioral support nurse (BSO), personal support workers (PSW), physician, family members, substitute decision maker (SDM), environmental services manager, registered dietitian (RD), dietary aid, Residents' Council president, Residents' and Family Council assistant.

During the course of the inspection, the inspector(s) conducted tour of all home areas, observed meal and snack service, reviewed clinical records, observed provision of care, reviewed residents and Family Council minutes, the home's policies and procedures, menu, staffing schedules.

The following Inspection Protocols were used during this inspection:

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
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

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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

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

Review of the resident assessment protocol (RAP) dated May 21, 2014, indicated resident #242 had moderately impaired - limited vision; not able to see newspaper headlines, can identify objects, and can see large print only. The resident does not wear glasses but can identify staff and family. There is no decline of vision in this quarter and does not wear visual appliances such as glasses; contact lenses; magnifying glass.

Interview with ADON indicated the resident was admitted in the home as legally blind, and he/she can see objects or staff as shades. Interview with an identified staff indicated the resident is able to see, he/she is eating independently, he/she never reads or watches TV, but listens to the radio only. The staff was not aware that the resident had impaired vision.

Interview with the resident confirmed that he/she has problems with the vision and he/she is able to read large prints only.

Review of the written plan of care and interview with identified registered staff indicated the vision section with vision interventions was missing in the written plan of care in order for staff to be aware of the resident's impaired vision and give clear directions to staff. [s. 6. (1) (c)]

2. Review of the written plan of care for resident #251, the section for skin and wound revealed that the resident needs to be turned and repositioned, to have ointments and/or creams applied and to use other protective skin care. The area that identifies how the care is to be delivered was left blank.

The kardex does not identify how these interventions will be provided to the resident by PSWs. The written plan of care instructs the direct care staff to apply barrier cream to perineum and zinc oxide to coccyx with each incontinent product change, and to turn and reposition the resident every two hours, but did not give direction on other protective skin care.

Record review of the medication administration record indicated to clean the stage two ulcer with normal saline, protect the peri-wound area, cover with Allevyn thin and change every five days and whenever necessary. Other order indicated to use clotrimaderm topical ointment two times a day to peri-area and a third order was to apply zinc ointment to coccyx and perineum area after incontinence change.

Interviews with an identified staff, registered nursing staff and NM revealed that the kardex and the written plan of care were incomplete and did not provide clear direction to the direct care staff. [s. 6. (1) (c)]

3. Review of the clinical record for resident #009 identified responsive behaviors in MDS, RAPs and progress notes as yelling, speaking loudly, being verbally aggressive, impatient, striking out with hands, slamming doors, presenting sexually unwelcome

behavior, such as feeling the private parts of other people, and refusing medications. The record review identified these behaviors as occurring around meal times in the dining room, the TV lounge and when wandering around in the hallways of the two home areas. The interventions for the resident were identified as educating resident to limit his/her personal approach and to redirect when he/she is too close to other residents, ensure his/her whereabouts and redirect to home area, explain that touching others is not appropriate manner to engage in a friendship relationship, complete hourly safety checks, inform the SDM of strategies that are implemented, monitor behaviors and underlying causes, monitor resident and perform daily observation of activities and to provide support to the resident to decrease his/her distress.

The kardex which was available to the PSWs in Point of Care that provides direction, did not identify the responsive behaviors the resident was displaying through yelling, speaking loudly, being verbally aggressive, impatient, striking out with hands, slamming doors and the interventions that were identified were not specific to the responsive behaviors displayed.

Interviews with the PSWs, registered nursing staff and BSO nurse confirmed that the plan of care did not set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Observation conducted on July 23, 2014 at 11:00 a.m. indicated a sign for contact precautions on resident #52 room.

Interview with ADOC indicated the resident was positive on antibiotic resistant microorganisms at one part of his/her body since admission.

Interview with direct care staff and review of the written plan of care for resident #320 does not indicate the resident is positive for antibiotic resistant microorganism at one site of his/her body therefore it does not give clear direction to staff for contact precautions. [s. 6. (1) (c)]

5. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of the MDS documentation, quarterly assessments, for resident #273

indicated the resident had impaired vision in 2013, on June 13, September 09, December 11, 2013, with no vision appliances used. In 2014, the assessments on March 03 and June 10, 2014, indicate the resident had adequate vision.

Interview with an identified PSW indicated the resident never wears glasses, he/she likes watching TV, and during program activities he/she never reads books but the staff is reading. The resident is able to walk independently.

Review of the written plan of care and interview with identified staff and registered nursing staff indicated staff did not collaborate with each other in the assessment of the resident's vision. [s. 6. (4) (a)]

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

A review of the plan of care of resident #251 revealed that "snacks may be left in the resident's fridge as per the family request, if the resident is not in her room" (created on July 4, 2014). A review of a progress noted made on January 13, 2014, revealed a note if the resident refused snacks during snack time to put them in the fridge for later use.

Interview with the private care giver and the family confirmed that on July 4, 2014, when the resident was not in his/her room staff did not save his/her nourishment (snack) in his/her fridge. [s. 6. (7)]

7. Review of the clinical record and interview with IPAC leader, indicated on February 10, 2014, resident #51 was positive for Antibiotic resistive microorganism in nares.

The IPAC excel data sheet presented by the IPAC leader indicated the resident was colonized with antibiotic resistive microorganism in both eyes and he/she was considered as resolved therefore he/she did not need contact precautions. The IPAC leader was not able to present evidence that the resident was colonized with antibiotic resistive microorganism in both eyes according to the data sheet and confirmed that the excel data sheet was wrong.

The written plan of care indicated the resident had to be on contact precautions. Review of the laboratory results indicated the resident was positive for antibiotic resistive microorganism on axilla on February 06, 2014, and nares on February 06

and 10, 2014, and negative on March 31, 2014, at both locations. No any evidence was found that the resident was positive in eyes.

Observation performed on July 23, 2014, at 1:00 p.m. revealed no sign on the resident door for contact precautions as per the written plan of care and the home policy. [s. 6. (7)]

8. Review of the written plan of care for residents #009 in relation to responsive behavior indicated the resident had cognitive loss/dementia or alteration in thought processes related to Alzheimer's, communication problem related to language barrier, history of wandering and aggressive behavior related to dementia/Alzheimer's and unwelcome behaviors.

Record review revealed the home initiated daily observation sheet (DOS) tracking tool from September 30, to October 10, 2013. This tracking tool was to be completed every 30 minutes in order to identify the resident's behaviors at different times of the day related to a responsive behavior incident that occurred on September 30, 2013. The tool was incomplete on September 30, October 1, 2, 3, 4, 5, 6 and 7, 2013.

Staff interviews with the PSWs, registered nursing staff and BSO nurse confirmed that the resident's care set out in the resident's plan of care was not provided as specified in the plan and the resident's behavior was not monitored every 30 minutes as required. [s. 6. (7)]

9. The licensee failed to ensure that, if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

A review of a plan of care for resident #238 revealed that the resident had falls on January 28 and 30, 2014. In both situations, the resident slid down from the reclining chair. The interventions included pain monitoring and PRN analgesic (initiated on November 19, 2012), provide staff assistance for ambulation and encourage the resident to pull the call bell (initiated on December 22, 2013). After the resident had two consequent falls caused by sliding from the reclining chair, no new approach was initiated to prevent further falls.

Interview with the registered nursing staff, PT, and the ADON-lead of the falls prevention program confirmed that the home did not evaluate the effectiveness of the

interventions created to prevent falls of the resident after the resident fell on January 28 and 30, 2014. They also indicated that different approaches have not been considered in the revision of the plan of care (date of the next revision before May 13, 2014). [s. 6. (11) (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 sets out clear directions to staff and others who provide direct care to the resident, the care set out in the plan of care was provided to the resident as specified in the plan, the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, 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 licensee's skin care program policy V3-1400 is complied with.

Interview with the ADON and review of the licensee's skin care program policy V3-1400 confirmed that the registered staff was expected to obtain a physician order for treatment of altered skin integrity following the approved corporate skin protocol as appropriate.

Review of the clinical record for resident #329 and interview with registered nursing staff revealed that on June 30, 2014, a blister was identified on the resident's right heel. The blister was assessed on July 8, 2014, and the physician endorsed the wound care protocol to be followed. The skin assessment on July 11, 2014, indicated the wound was stage two. Interview with registered staff indicated on July 16, 2014, the physician was contacted to order a treatment according to the wound care protocol and the staff did not notify the physician about the exact stage of the wound. Interview with the registered staff and record review confirmed that the treatment for stage three wound care protocol was added to the physician order and the treatment assessment record (TAR) on July 16, 2014. Staff interview and record review confirmed that there was no physician order obtained on July 16, 2014, for treatment of resident's stage two wound with the stage three wound care protocol. [s. 8. (1) (b)]

2. Review of the homes' policy titled Medications – Emergency Drug Box, Number: V3 -940, revised April 13, 2014, states in the policy "each Leisureworld Home will maintain an approved supply of emergency medication in a locked emergency medications box in a locked medication room or cupboard in a designated area". This policy identified that "Medications not approved by the Medical Director cannot be supplied by the pharmacy for the emergency drug box". The policy further indicates under the procedure section the following "For narcotics used from the Emergency Drug supply, ensure the appropriate narcotic count sheet is prepared and/or completed".

The inspector observed on July 10, 2014, the emergency medications box. This box did not contain the approved supply of medication. The following medications were either over supplied or under supplied.
Amoxicillin 250mg - under by 6
Amoxi-Clav 500 mg – under by 2
Azithromycin 25omg – over by 3
Cefuroxime 250 mg (Ceftin)- over by 18
Keflex 250 mg plus 18Bid 1000mg – under by 1
Avelox 400mg – over by 9
Imodium 2mg – over by 2
Coumadin 1mg – under by 1
Coumadin 2.5 mg – over by 3
Coumading 2mg – over by 14
Coumandin 3 mg – over by 8
Coumadin 4 mg – under by 1

Couomadin 5mg – under by 1
Tobramycin eye drops short by 1
Gravol 50mg/ml x 5ml inj – over by 2
Diazepam 10 mg/2ml inj. over by 4
Benadryl 50mg/ml x 1 ml inj – over by 4
Glucagon Inj kit over by 1
Lorazepam 4 m/ml inj should be 4 – under by 4
Morphine 15ml/ml x 1ml inj should be 10 under by 1
E-pen ink cartridges missing 1 pkg
G tube Unclog kit (Viokase) and Sodium Bicarbonate 500 mg – over by 4

The inspector observed that the narcotic count was not accurate. There should have been 10 Morphine vials of 15 milligrams per milliliter. Instead the count sheets indicated that the count was only 9 on July 10, 2014.

The evening NM and ADON confirmed the above counts were accurate and that the home did not comply with the policy that an approved supply of emergency medication is maintained in the emergency drug box. They also confirmed that the morphine count was short by 1 and began an investigation into the missing Morphine.

The home's policy titled Medication Management – Drug Destruction, Number: V3-930, revised April 2013, indicates the following "Medications that are to be destroyed and disposed of are to be stored safely and securely. Leisureworld suggest that each nursing station will have a known storage area for iscontinued or outdated medications that is separate from drugs that are currently available for administration".

The inspector observed on July 17, 2014, in the 3A medication room in the upper cupboards with routine stock medication the following:
A box containing 8 Scopolamine ampoules that were ordered on January 23, 2014, for resident #002 remained on the shelf in the medication stock cupboard. Kayexalte ordered on May 9, 2012, for resident #003 remained on the shelf in the medication stock cupboard.

The medication room has a specific area in the lower cupboard to store discontinued medications. The registered nursing staff and the casual part-time NM confirmed that these medications should have been discontinued and destroyed at the time identified by the resident's death and should not have remained in the stock medication

cupboard. The home did not follow the above mentioned policy. [s. 8. (1) (b)]

3. The licensee failed to ensure that the policy for Management of MRSA is complied with.

Review of the policy Management of MRSA, revised on August 2013, states: additional precautions may be discontinued when a minimum of 3 sets of negative specimens taken at least one week apart are achieved, and in consultation with the home's Infection Control Designate. If additional precautions have been discontinued, monthly screening for six months is recommended since re-colonization can occur.

Review of the IPAC excel data sheet presented by IPAC leader for resident #53 indicated the resident did not need contact precautions because the colonization with antibiotic resistive microorganism was resolved as per the laboratory results two negative at the end of 2013 and one negative at beginning of 2014. Review of the clinical record, laboratory results and interview with IPAC leader confirmed that one of the laboratory results at the end of 2013 was positive for antibiotic resistive microorganism and no other negative results were located in the chart.

Observations on July 23, 2014, at 1 p.m. revealed there was no sign for contact precautions on the resident door according to the home's policy. The home policy for discontinuation of additional contact precautions was not complied with.

Review of clinical records and interview with the IPAC leader indicated resident #50 was colonized with MRSA on March 10, 2014, and negative on May 06, 2014, and July 03, 2014 in nares, axila and rectum. The sign for contact precautions and use of personal protective equipment (PPE) was not applied on the resident door to notify staff according to the home's policy. The evidence presented by the IPAC leader indicated the MRSA colonization was resolved and the resident did not need contact precautions.
The home policy for discontinuation of additional contact precautions was not complied with. [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 to ensure that the skin care program policy V3-1400, Medications – Emergency Drug Box V3-940, management of MRSA, put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Review of the clinical record indicated on February 20, 2014, at 9:45 a.m., resident #12 had a fall from the shower chair in front of the shower room while being transported from the room to the shower room. Interview with a PSW indicated he/she was behind the shower chair pulling it towards the shower room while trying to enter the shower room. The resident was restless and fell with the head forward hitting the floor and sustaining multiple skin tears to the forehead, both hands, right knee and right great toe and was transferred to hospital.

Review of the operating and product care instructions for the shower chair called "Carino", purchased by Arjo, in the section for transfer, indicated three different possible ways to transfer/transport the resident in the Carino to the shower room. A warning with exclamation mark states that staff has to observe the arms and legs of the resident to ensure safe passage of the chair through narrow doorways.

Method 1 describes that Carino is pushed from the back of the wheelchair and the resident's feet are placed on the foot support.
Method 2 is described as a preferred method for short residents. The Carino is pushed from the front side of the wheelchair and the resident's legs are placed on the leg rests.
Method 3 describes that Carino is pushed in a high position from the front side, the resident does not use foot supports or leg rests.

Observation of the shower chair Carino on July 21, 2014, on the unit 4A and interview with Environmental supervisor revealed missing parts for the leg support.

Interview with an identified staff indicated the shower chair Carino was pulled with the resident in it, and she/he was not aware of the safe transferring technique according to the manufacturing instructions. (method 1 or method 2). [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use the shower chair Carino in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviors, written approaches to care, including identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other.

Review of the clinical record for resident #009, revealed that written approaches to care were developed and included the following: the resident had cognitive losses, alteration in his/her thought process, a communication problem, history of wandering, aggressive behavior and unwelcome behavior.

The resident's plan of care did not identify any behavioral triggers that resulted in his/her responsive behaviors.

The communication problem of the resident was related to the resident being of another culture and limited English.

The resident had wandering episodes prior to admission and continued to wander from one home area to another. The plan of care did not identify triggers to wandering patterns within the home.

The plan of care identified the aggressive behavior but did not specify the type of the aggressive behavior (displayed by yelling, speaking loudly, being verbally aggressive, impatient, striking out with hands, slamming doors) or what the triggers for these behaviors are.

The behavioral triggers were not identified for the unwelcome behavior.

Interview with the identified staff and BSO nurse confirmed that the triggers for the resident's responsive behaviors were not identified. [s. 53. (1) 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 the following are developed to meet the needs of residents with responsive behaviors, written approaches to care, including identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations specifically policies that are relevant to the

person's responsibilities.

Review of the clinical record indicated on February 20, 2013, at 9:45 a.m., resident #12 had a fall from the shower chair in front of the shower room while being transported from the room to the shower room. Interview with an identified staff indicated he/she was behind the shower chair pulling it towards the shower room while trying to enter the shower room. The resident was restless and fell with the head forward hitting the floor and sustaining multiple skin tears to the forehead, both hands, right knee and right great toe and was transferred to hospital for assessment.
Review of the operating and product care instructions for the shower chair called "Carino", purchased from Arjo, in the section for transfer, indicated three different possible ways to transfer the resident in the Carino chair to the shower room. A warning with exclamation mark states that staff has to observe the arms and legs of the resident to ensure safe passage through narrow doorways.

Method 1 describes that Carino is pushed from the backside and the resident's feet are placed on the foot support.
Method 2 is described as a preferred method for short residents. The Carino is pushed from the front side and the resident's legs are placed on the leg rests.
Method 3 describes that Carino is pushed in a high position from the front side, the resident does not use foot supports or leg rests.

Review of the home's educational records and interview with identified staff indicated the staff were not trained in 2012 or 2013 on how to use the shower chair Carino implementing the safe transferring techniques according to the manufacturing instructions. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provides direct care to residents receive as a condition of continuing to have contact with residents, training relating to mental health issues, including caring for persons with dementia.

Review of the home's educational records identified an average of 37 per cent of the staff received retraining in caring for persons with dementia in 2013.

Interview with ADOC confirmed the home did not ensure that all staff who provide direct care to residents received training relating to mental health issues, including caring for persons with ementia. [s. 76. (7) 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 persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, all staff who provides direct care to residents receives, as a condition of continuing to have contact with residents, training relating to mental health issues, including caring for persons with dementia, all staff who provides direct care to residents receives training in behaviour management, to be implemented voluntarily.

WN #6: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation conducted on July 23, 2014, at 11:40 a.m., on 3A, revealed that the personal health information of resident # 013 including the resident name and medication administration details were on the screen of the unattended medication cart.

Interview with the an identified staff confirmed that that the screen was left opened while the registered nursing staff was away from the cart and the personal health information on the screen was visible to visitors or other residents. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are provided with food that is adequate in quantity.

Observation conducted in the kitchen on July 10, 2014, at 2:00 p.m., revealed that standardized scoop size was not used when pouring pureed nourishment for evening snack. Scoops size #30 (30 ml) was used instead of #12 (80 ml) for pureed turkey sandwich.

A review of home's week 3, Thursday, snack menu revealed that scoop #12 should be used for pureed turkey sandwich.

Interview with an identified staff confirmed that scoop size should be used as indicated in the menu for pureed turkey sandwich.

Interview with FSM confirmed that appropriate scoop sizes should be used for all food items as per the menu, as using different scoop sizes may alter the quantity and nutrient value of the food. [s. 11. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system clearly indicate when activated where the signal is coming from.

Observation performed on July 9, 2014, revealed that the call bell in the bathroom of room #221 was not working and did not indicate any signal (visual or auditory) when activated. The inspector informed the registered staff and the staff indicated they were not aware of this and will send an email to the maintenance staff to fix it. On the next day, interview with the environmental services manager confirmed that the department received the email request, the cause of the malfunction was identified and the call bell was fixed the same day. [s. 17. (1) (f)]

WN #9: 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:
4. Vision. 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of the resident's vision.

Review of the Resident Assessment Protocol (RAP) from June 11, 2014, indicated resident #255 can see large print, but not regular print in newspaper or books. The Minimal Data Set (MDS) assessments from March 19, May 19, and June 11, 2014, indicated the resident had impaired vision and no visual appliances.

During an interview the resident was not able to confirm if he/she was assessed by an eye specialist. Review of the resident chart and interview with registered staff indicated resident #255 was not assessed by an eye specialist in 2013 or 2014 for the

impaired vision. [s. 26. (3) 4.]

2. Review of the MDS documentation for resident #273 indicated the resident had impaired vision on June 13, September 09, and December 11, 2013, with no vision appliances and adequate vision on March 03 and June 10, 2014.

Interview with an identified staff indicated the resident never wears glasses, he/she never reads books during program activities but the staff is reading, he/she watches TV only, and he/she walks independently.

Review of the clinical chart and interview with registered nursing staff confirmed resident #273's vision was not assessed by an eye specialist in 2013 or 2014. [s. 26. (3) 4.]

3. Review of the RAP dated May 21, 2014, indicated resident #242 had moderately impaired - limited vision; not able to see newspaper headlines, but can identify objects, can see only large print. The resident does not wear glasses but can identify staff and family. There is no decline of vision in this quarter and does not wear visual appliances such as glasses; contact lenses; magnifying glass.

Interview with ADON indicated the resident was admitted in the home as legally blind, and can see objects or staff as shades. Interview with an identified staff indicated the resident is able to see, is eating independently, never reads or watches TV, but only listens to the radio.

Interview with the resident confirmed vision problems. He/she is able to read large prints only and nobody told him/her or his/her POA to be seen by the eye specialist who is coming in the home every year.

Review of the resident #242's record confirmed the resident's vision was not assessed by an eye specialist in 2013 or 2014. [s. 26. (3) 4.]

4. The licensee failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the residents, mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Review of the written plan of care for residents #009 in relation to responsive behavior indicated the resident had cognitive loss/dementia or alteration in thought processes related to Alzheimer's, communication problem related to language barrier, history of wandering and aggressive behavior related to dementia/Alzheimer's and unwelcome behaviors toward other residents.

Record review revealed the home initiated daily observation sheet (DOS) tracking tool from September 30, to October 10, 2013, in order to identify the resident's triggers for the resident's behaviors at different times of the day. The information collected was not used to create an individualized plan of care for the responsive behavior (the time, location or other contributing factors).

Interviews with identified staff, registered nursing staff and BSO nurse confirmed that the resident's plan of care did not identify potential triggers, behavioral patterns or variations in the residents functioning at different times of the day. [s. 26. (3) 5.]

WN #10: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

The licensee uses a skin assessment and a weekly skin assessment instrument in the electronic documentation to assess residents exhibiting altered skin integrity. Interview with the registered staff and the ADON indicated that the skin assessment instrument should be used for assessing new skin issues.

Record review and interview with the registered staff and the ADON confirmed that when in the middle of 2014, a blister was identified on the resident #329's right heel the skin assessment was not performed using the skin assessment instrument. The the skin assessment was performed and documented 10 days after it was noticed. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Record review and interview with an identified staff revealed that resident #329 had a right heel blister identified on in the middle of 2014. MD assessed the resident one week after it was noticed and endorsed the wound care protocol for cleansing the wound with normal saline, pat dry and cover with tegaderm. The wound care protocol was transcribed into electronic treatment administration record (eTAR) on the following day but the resident did not receive the treatment 11 days after it was noticed. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that the 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 licensee uses a weekly skin assessment tool in PointClickCare to assess altered skin integrity of residents. Record review and interview with registered staff revealed that resident #329's right heel blister was identified on June 30, 2014. The first skin assessment was completed on July 4, 2014, by a registered staff without using the skin assessment tool. A weekly skin assessment was performed on July 11, 2014. Record review and staff interview confirmed that there was no weekly skin assessment performed in the period from July 12, to July 21, 2014 for the resident's right heel blister. [s. 50. (2) (b) (iv)]

4. On July 10, 2014 the MDS data revealed that resident #251, had a worsening pressure ulcer to his/her coccyx, and the pressure ulcer evolved from stage one to stage two pressure ulcer.

Record review revealed the skin and wound assessment tool was not completed on April 14, May 22, and June 5, 2014.

Interviews with a registered nursing staff and NM confirmed that the skin and wound assessments were not completed on a weekly basis for this identified worsening pressure ulcer. [s. 50. (2) (b) (iv)]

5. The licensee failed to ensure that the resident who is dependent on staff for

repositioning is repositioned every two hours as required depending upon the resident's condition and tolerance of tissue load.

Record review revealed that resident #251, who had a worsening pressure ulcer was not turned and repositioned on October 31, and December 22, 2013, January 19, February 7, March 1, 21, 26, 27, 2014, every two hours.

Staff interviews with the PSW, registered nursing staff and NM confirmed the resident was not repositioned every two hours. [s. 50. (2) (d)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The licensee uses a Residents' Council concern form to record the council's concern, the department head's written response and the administrator's approval for the response. After the approval, the Residents' Council will review the response.

Record review of the concern form revealed a laundry concern was raised by the council on February 11, 2013. Record review and interview with the council's assistant and the administrator confirmed that the written response was approved by the administrator on March 3, 2013. The licensee did not respond to the Residents' Council in writing within 10 days of receiving the council's concern.

Record review of the concern form revealed that a television noise concern was raised by the council on September 9, 2013. Record review and interview with the council assistant and the ADOC confirmed that the written response was completed by the ADOC and given to the Residents' Council on October 15, 2013. The written response was not provided within 10 days period since receiving the concern. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutrition and Hydration program includes, a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

A record review revealed that the licensee did not measure the heights of 14 residents in 2013, and the height of two residents in 2012, and 2013.

Interview with identified staff confirmed that the home has a policy to measure residents' height on admission, annually and at the time of significant change in status of the resident. The identified staff confirmed the resident's height was not measured annually.

Interview with the DOC confirmed that the home missed measuring the height of residents due to the transition into a new documenting program, however the home is aware and already started measuring the height of residents for the current year. [s. 68. (2) (e) (ii)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all fluids in the food production system are prepared using methods to, preserve taste, nutritive value, appearance and food quality.

The inspector observed the cook preparing herb sauce for veal in the kitchen on July 10, 2014, at 2.10 p.m. The cook added margarine, some herbs and milk to the sauce pan to make the herb sauce. The cook added the herbs without measuring them before adding milk to the recipe.

A review of a recipe of herb sauce indicates, 2.035 liter of margarine melted, 56 ml of parsley flakes dry, sage ground, basil dried and rosemary dried are part of the ingredients. Recipe indicates to add herbs after adding milk.

Interview with the cook confirmed that he/she used 1 liter of margarine instead of 2 liters because he/she thinks that 2 liters of margarine would be too much for the recipe.

Interview with FSM confirmed that changes in the recipes are not allowed to be made. If any changes are to be made, the FSM needs to approve the changes before they are implemented. By changing the amount of margarine in the recipe, the taste, quality and nutritive value of the herb sauce would be affected. [s. 72. (3) (a)]

2. The licensee failed to ensure that the home has and that the staff of the home comply with, a cleaning schedule for the food production area.

The inspector observed the kitchen on July 10, 2012, at 2:00 p.m., and noted deposition of dust on the top surface of the steamer.

Interview with identified staff confirmed that the kitchen equipment is cleaned twice a week. The steamer was cleaned two days ago, however, the surface on the top of the steamer was not cleaned.

Interview with the FSS confirmed that the dust deposited on the steamer could be a risk for cross contamination. [s. 72. (7) (c)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Residents' Council and the Family Council is sought, if any, in developing and carrying out the survey, and in acting on its results.

Interview with the president of the Family Council confirmed that the Family Council had no input in development and carrying out the satisfaction surveys.

Interview with the director of programs confirmed that the satisfaction surveys are provided by Leisureworld Corporate and the Family Council has no part in the development and implementation of the satisfaction surveys. [s. 85. (3)]

2. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Interview with the Residents' Council president revealed that the licensee did not seek advice of the Residents' Council in developing and carrying out the satisfaction surveys.

Interview with the council's assistant and the executive director confirmed that the licensee uses abaqis system for conducting the satisfaction surveys and they did not seek the advice of the Residents' Council. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident or destroyed.

The inspector observed on July 10, 2014, while checking the medication cart on an identified floor, that an inhalation applicator was not labeled or being in the original packaging for resident #238 and that the packaging was not present on the medication cart. The labeled box with the label for the resident was found in the cupboard in the medication room.

Interviews with identified staff confirmed that the medication box that was labeled did not fit in the medication cart so they removed the inhalation applicator and placed it in the medication bin belonging to the resident and confirmed they knew it was not labeled. An interview with the evening NM confirmed he/she did not know who this medication belonged to. The medication did not remain in the original labeled package.

In the medication cart, in the medication bin identified for resident #001, the inspector found an unlabeled vial of an identified medication. Review of the residents' chart revealed that the resident did not have prescription for the medication.

Interviews with the registered nursing staff revealed that the medication did not belong to this resident but to another resident who passed away. The registered nursing staff did not know how the unlabeled vial of the medication ended up in resident #001's medication bin.

Interviews with the registered nursing staff and evening NM confirmed that all drugs must remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident or destroyed. [s. 126.]

WN #16: 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 is used exclusively for drugs and drug-related supplies.

On July 17, 2014, the inspector observed a plastic food container containing someone's food in the third floor medication room fridge.

Interviews with the registered nursing staff and NM confirmed that the medication fridge is for medications only. [s. 129. (1) (a)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The home failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which, is recorded the following information, in respect of every drug that is ordered and received in the home: the strength and quantity of the drug is recorded, the date the drug is received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home.

The inspector observed on July 16, 2014, in the first floor nursing station the Drug Record binder, the binder was divided into two areas, one area for medications ordered and reorders and the second area for medications received.

The home's process for ordering and reordering medications is as follows: the day registered nursing staff orders the medication as prescribed by the physician and hand writes the order into the medication reorder sheet if it is a new order. If the medication is a reorder this is done by e-mars, if it is a PRN medication or treatment and has a peel off label the label would be placed onto the reorder sheet. This reorder sheet is to include the "name of the patient or prescription number, drug name and strength, nurse who orders drug, date ordered, date received and by whom" as per the medication reorder sheet.

The new medication is received on the evening shift by the registered nursing staff but the registered nursing staff does not note the date received and by whom on the medication reorder sheet. The receiving nurse instead, is to check the medication received against the "Shipping Report" from the pharmacy, identifying the total number of prescriptions received, the total cards received, and the registered nursing staff who receives the medication would then sign their name on the shipping report. The registered nursing staff for each medication received is also to check for accuracy and
initials in the received column indicating they have checked each of the prescriptions.

The record review of the drug record binder revealed on July 16, 2014, the medication reorder sheet for the following residents:

For residents #004, #005, #006 and #007 there were orders for certain medications and these new medication orders did not include the drug strength and the quantity.

The shipping reports for the above noted medications could not be located in the Drug Record Binder.

The shipping reports dated May 16, 30, July 11, 2014, were not completed as required: initials, date medication received, number of medication cards/sleeves received, one report was struck out with an X and no signature of the registered nursing staff who received the medications.

The registered nursing staff when reviewing the medication reorder sheet with the inspector agreed it appeared that the residents did not receive their medications. The ADON confirmed the system is not organized and not completed as required by the regulations. [s. 133.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, falls prevention and management training is provided to all staff who provide direct care to residents.

A review of the staff training attendance record for falls prevention and management revealed that 28.2% of the direct care staff were not provided the training in 2013.

Interview with the ADON confirmed that not all direct care staff were provided training in falls prevention and management in 2013. [s. 221. (1) 1.]

2. The licensee failed to ensure that, for the purposes of paragraph 6 of subsection 76 (7) of the Act, training in skin and wound care is provided to all staff who provide direct care to residents.

A review of the staff training attendance record for skin and wound care revealed that 12 % of the direct care staff did not receive training in 2013.

Interview with the ADON confirmed that not all direct care staff who provide direct care to residents were provided training in skin and wound care in 2013. [s. 221. (1) 2.]

WN #19: 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. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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

Findings/Faits saillants :

1. The licensee failed to ensure the designated staff member who co-ordinates the infection prevention and control program has the education in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management.

Interview with the designated staff member who co-ordinates the IPAC program indicated the staff was assigned to the role two years ago and did not have any education in IPAC practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. [s.

229. (3)]

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

Observation on July 09, 2014, at 1:55p.m., in an identified room on 4th floor, the shared washroom, revealed a non-labeled toothbrush on the sink counter.

On July 09, 2014, at 2:40 p.m., in two other rooms on 4th floor, the shared bathrooms, the inspector observed non-labeled white urine collection basins on the counter.

Observation was performed on July 21, 2014, in two rooms on 2nd floor with shared washrooms. In one of the washrooms was noted a non-labeled toothpaste and toothbrush in a K-basin, and another toothbrush with the same color in another K-basin on the same counter. In the other room was noted a non-labeled toothbrush. Interview with identified staff indicated all personal care items should be labeled but because the toothbrushes get changed more often than other items they did not succeed to label them.

On July 22, 2014, at 11:45 a.m., observation of the shower room on 1st floor and interview with identified staff revealed six personal hygiene basins with different colors located on the shower commode, of which some were labeled, some were non-labeled, and mixed together clean and dirty. [s. 229. (4)]

3. The licensee failed to ensure the information that was gathered on every shift about the residents' infections, is reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

Review of the IPAC monthly data sheets indicated a resident on 3rd floor was resolved for the antibiotic resistant microorganism colonization and did not need a sign on the door for contact precautions because the laboratory results were negative (two at the end of 2013 and one in 2014). Review of the clinical record and interview with the IPAC leader indicated one of the laboratory results from the end of 2013 was positive for an antibiotic resistive microorganism in nares but no other results, either positive or negative were found.

Observation of the 3rd floor indicated a sign on one of the rooms for contact precautions, but the IPAC data sheet was not updated with this resident.

The IPAC leader confirmed the IPAC monthly data was not updated and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infections. [s. 229. (6)]

4. The licensee failed to ensure residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of the clinical records, and interview with the infection prevention and control (IPAC) designated leader indicated since 2012 new admitted residents sign a consent for receiving tetanus and diphtheria immunization but it is not actually administered, neither is available in the vaccination fridge. [s. 229. (10) 3.]

Issued on this 4th day of September, 2014

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

Slavica Vucko