Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2014	2014_378116_0005	T-58-14	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 - LAWRENCE
2005 LAWRENCE AVENUE WEST, TORONTO, ON, M9N-3V4

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

SARAN DANIEL-DODD (116), ARIEL JONES (566), JUDITH HART (513), TILDA HUI (512)

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, 24, 2014.

The following complaint inspections were conducted in conjunction with the RQI:
Log T-674-14 (inspection #2014_378116_0006) and T-536-14 (inspection #2014_378116_0007).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), nurse managers, registered staff, registered dietitian, environmental services manager (ESM), environmental services supervisor, resident assessment instrument (RAI) coordinator, dietary aides, programs manager, office manager, housekeepers, physiotherapists, personal support workers (PSW), Residents' Council president, Family Council representative, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed staff to resident interactions and provision of care, observed meal service, medication administration, reviewed relevant home records, relevant policy and procedures, training records, employee records and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
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. (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 following non compliance is in relation to findings identified under T-536-14 (inspection #2014_378116_0007), which was conducted in conjunction with this inspection.

A review of resident #001's health record did not provide clear directions regarding the usage of a topical cream. A physician's order and the written plan of care stated the following: "may keep topical creams in his/her room as per request of resident power of attorney (POA) and medical doctor (MD) recommendation". The physician's order does not indicate who is responsible for the application of the cream.

Interviews with registered staff, PSWs and the DOC confirmed that the topical creams were not applied to the resident over a specified period of time, and that the plan of care did not provide clear directions regarding the application of the topical cream. [s. 6. (1) (c)]

2. The following non compliance is in relation to findings identified under T-536-14 (inspection #2014_378116_0007), which was conducted in conjunction with this inspection.

The written plan of care for resident #002 did not set out clear directions for staff related to toileting of the resident.

On a specified date, the resident was observed being transferred from his/her wheelchair to the toilet. It was noted that he/she was transferred using a Sabina (standing lift) with the assistance of two staff.

The resident's written plan of care for transfers documents that he/she is transferred manually by two staff. The minimum data set (MDS) conducted on a specified date, documents the resident requires a Sabina mechanical lift for transfers. Interviews with staff confirmed that they transfer the resident to the toilet consistently using a Sabina lift. The written plan of care does not specify that the resident requires the use of a Sabina lift for toilet transfers.

Interviews held with the assigned PSW and DOC confirmed that the plan of care did not provide clear directions regarding the use of a Sabina lift for toilet transfers. [s. 6. (1) (c)]

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

A record review of the care plan and diet list for resident #747 directed staff to serve the resident all courses at once at all meals to enhance intake. During the lunch meal service on a specified date, the resident was observed to be served course-by-course. Interviews with an identified PSW and RPN indicated that resident #747 receives his/her meal service course-by-course, like the other residents on the unit. An interview with the home’s dietary manager revealed that the resident should be served all courses at once at all meals, and that it is clearly outlined for staff on the care plan, dietary list, and preference/choice sheets. The dietary manager confirmed that the care set out in the plan of care was not provided to resident #747 as specified in the plan. [s. 6. (7)]

4. The following non compliance is in relation to findings identified under T-674-14 (inspection #2014_378116_0006), which was conducted in conjunction with this inspection.

The written plan of care for resident #689 identified that to decrease symptoms of gastroesophageal reflux disease (GERD) the resident is encouraged to remain upright for a minimum of 30 minutes following meals.

On a specified date, resident #689 finished his/her lunch and remained seated on the

bed. The inspector returned to the room approximately 10 minutes later and observed the resident to be lying on his/her side in bed.

Interviews held with the assigned PSW and registered staff confirmed that the resident is to remain in an upright position for at least 30-40 minutes after each meal and that care was not provided as specified in the plan. [s. 6. (7)]

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

The plan of care for resident #798 indicates the resident has compromised skin integrity.

An interview held with an identified registered staff confirmed that he/she was unaware of the resident’s compromised skin integrity, which requires treatment. [s. 6. (8)]

6. Record review of resident #684's written care plan revealed that the resident has a communication problem related to his/her disease process. Specific interventions were outlined within the care plan to enhance the resident's communication.

An interview with a PSW indicated that resident #684's ability to communicate fluctuates, and that there are no specific communication interventions used with this resident.

Record review of resident #747's written care plan revealed that the resident has a communication problem related to his/her diagnosis and a language barrier. Specific interventions were outlined within the care plan to enhance the resident's communication.

On a specified date, an identified PSW was observed interacting with resident #747 while providing care and did not follow any of the specific communication interventions as outlined within the written plan of care.

Record review of resident #827's written care plan revealed that the resident has a communication problem related to his/her disease process. Specific interventions were outlined within the care plan to enhance the resident's communication.

An interview with an identified PSW indicated that resident #827 communicates well. The PSW stated further that there were no specific communication interventions used with this resident outside of explaining steps when providing care.

An interview with the DOC confirmed that staff and others are expected to review a resident's plan of care on a daily basis, in order to ensure they are aware of the contents of the plan of care. [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 to ensure that the plan of care provides the following:

1. sets out clear directions to staff and others who provide direct care to the resident,

2. that the care set out in the plan of care is provided to the resident as specified in the plan and,

3. that staff and others who provide direct care to a resident are kept aware of the contents 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 any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with.

The licensee's policy entitled Medications Government Stock (policy V3-980, revised April 2013), documents that government stock medications shall be inventoried and ordered on a one to three month basis. Any government stock medications past the expiration date are to be pulled from circulation at that time and disposed of in keeping with the medications disposal process.

On a specified date, the following expired medications were observed in the government medication stock room:

- 14 boxes (each box contained 100 Dulculax suppositories) with expiry date of April 30, 2014.
- five boxes (each box contained 10 dimenhydrinate suppositories) with expiry date of April 2014.
- seven boxes (each box contained 10 dimenhydrinate suppositories) with expiry date of June 2014.
- 12 tubes of Anuzinc ointment with expiry date of April 2010.
- one bottle of Entrophen with expiry date of June 2014.
- one container of resource thicken with expiry date of June 20, 2014, stored in the fridge on an identified home area.

Interviews held with registered staff and the Director of Care confirmed that the government stock room and medication carts are reviewed on a monthly basis for expired medications and the expired medications should have been discarded from the inventory. [s. 8. (1)]

2. The licensee failed to ensure that the home's Painting Schedule (policy #V8-320) reviewed April 2012, was complied with.

The home's Painting Schedule (policy #V8-320, reviewed April 2012), indicated that the environmental service manager (ESM) would develop an annual master painting schedule for the home, focusing on areas of priority, and that painting will be completed according to the master painting schedule by both in-house staff and corporate painters.

Observations of identified resident rooms and tub areas revealed marred, scuffed, and chipped walls requiring repair. A review of the home's residents' rooms painting

schedule 2014-2015 identified that one resident room is scheduled to be painted daily, but that only 26 rooms have been painted so far in 2014.

The ESM confirmed that the home's painting schedule is not being followed as per the home's policy. [s. 8. (1) (b)]

3. The Tuberculosis (TB) Screening Requirements for Staff (policy V6-310.10) states that a tuberculosis screening for all new staff must be initiated within six months before starting work or within 14 days of starting work.

The personnel records for staff A revealed that a tuberculosis screening was not initiated within six months before starting work or within 14 days of starting work. Staff A has worked several shifts since his/her hire date and has been in direct contact with residents as confirmed by the DOC.

The personnel records reviewed for staff B identified that the TB screening results were outside of the six month time frame.

The DOC confirmed that the home's TB screening requirements for staff A and B were not followed as per the home's policy. [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 where the home is required to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with related to the following areas:

1. Medications Government Stock
2. Painting Schedule
3. Tuberculosis (TB) Screening Requirements for Staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to 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 Skin Care Program (policy V3-1400), revised February 2012 states, the registered staff will complete a head to toe skin assessment within 24 hours upon a PSW report of altered skin integrity.

The progress notes for resident #718 document an open area with redness noted on an identified area of resident #718's body. Record review and staff interviews confirmed that a skin assessment has not been completed using a clinically appropriate assessment instrument.

The DOC confirmed that the initial wound assessment was not completed. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The progress notes for resident #718 indicated that resident #718 had an open area with redness on an identified area.

Review of the health record for a specified period, revealed that the weekly skin assessments were not conducted on a consistent basis as required.

Interviews held with registered staff and the DOC confirmed 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 to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment and weekly re-assessments by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of resident #668's minimum data set (MDS) assessment and resident assessment protocols (RAPs) revealed that the resident has a history of urinary incontinence over a specified period of time. Further review of the resident's clinical assessments revealed that the continence/bowel assessment, the instrument used by the home to assess incontinence, had never been completed for this resident.

Staff interviews confirmed that resident #668 wears pull up briefs for occasional urinary incontinence and that a continence/bowel assessment was not completed during the resident's most recent MDS quarterly review period.

A review of resident #684's MDS assessment and RAPs revealed that the resident has had a history of urinary incontinence over a specified period of time. Further review of the resident's clinical assessments revealed that the electronic continence/bowel assessment had never been completed for this resident.

Staff interviews confirmed that resident #684 is incontinent of bladder, requires total care for toileting, and that a continence/bowel assessment was not completed during the resident's most recent MDS quarterly review period.

An interview with the DOC confirmed that the continence/bowel assessment should be completed on each occasion that the continence RAP is triggered and that both resident #668 and #684 should have received a continence/bowel assessment during their most recent quarterly assessments. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, to be implemented voluntarily.

WN #5: 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).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours.

The written plan of care for resident #684 did not identify written strategies or interventions related to the resident's responsive behaviours or resistance to care.

Interviews with both an identified PSW and registered staff revealed that resident #684 is occasionally aggressive during care, especially while having his/her face washed, and that he/she will reportedly curse at staff or swat their hand away, as if to resist care. An interview with an identified RPN indicated that staff are reminded to leave the resident alone, give him/her time to calm down, and then re-approach when these behaviours are demonstrated. An interview with another identified RPN confirmed that the resident's written plan of care does not include anything about physical aggression or responsive behaviours.

The resident's written plan of care did not contain a section related to behaviours or resistance to care, or the management of these behaviours, as described by staff.

An interview with the DOC confirmed that occasional aggression is considered responsive behaviour and should be outlined in the resident's written plan of care. [s. 53. (1) 2.]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified.

The written plan of care for resident #731 documents the resident displays verbally abusive behaviour towards his/her roommate on a daily basis and that he/she is resistive to care from staff. The plan of care does not specify the behavioural triggers for the resident.

Interviews held with registered staff and PSWs confirmed resident #731 has occasionally been verbally abusive towards his/her roommate and were able to identify the specific triggers. The registered staff and the DOC confirmed that the identified triggers for the resident's behaviours should be documented in the written plan of care. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following are on place for residents demonstrating responsive behaviours:

- written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours and that for residents demonstrating responsive behaviours and,
- for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, to be implemented voluntarily.

WN #6: 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. (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 that residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded schedules posted on the Ministry website.

A review of the clinical record for residents #012 and #013 did not identify the date of the residents' last tetanus and diphtheria (Td) booster. The home's Immunization Resident (policy V6-131, revised August 2013), states that adults should get the Td booster every 10 years for continued protection, and that the registered staff will review admission information to determine if a resident has received both Pneumovax and Td vaccines.

An interview with the DOC confirmed that residents #012 and #013 had not received the Td booster as per the home's policy and in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded schedules posted on the Ministry website, to be implemented voluntarily.

WN #7: 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 equipment is kept clean and sanitary.

Over the period of the inspection, the inspector observed a padded bath chair in the tub/shower room on an identified home area to be soiled with dark brown particles.
In the tub/shower room on an identified home area, the tiles/grout in the shower stall were dirty and yellowed.
On a specified date, a soiled commode pail was observed to be stored on the floor under the sink in the tub room in an identified home area.

An interview held with the ESM confirmed that the identified personal care equipment required cleaning. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a good state of repair.

The following observations were noted:

In an identified Tub Room:
- water damage to ceiling in shower stall
- marred wall and chipped paint to north wall upon entry to the tub room
- metal door stop off the floor, resting on radiator in tub area

Identified Resident Rooms:
- marred south bedroom wall
- large, dark marking along length of radiator
- area on south wall near baseboard has been patched, but is unpainted

A review of the maintenance logs failed to reveal that the above areas requiring repair had been recorded on the monthly preventative maintenance audits, tub and shower room audits, or during daily rounds. An interview with the ESM confirmed the above noted areas required repair and that the home's resident rooms painting schedule has not been followed. [s. 15. (2) (c)]

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Record review failed to reveal the presence of an annual satisfaction survey for the home during 2013.

Interviews with the Residents' Council/Family Council assistant and the Administrator confirmed that the last satisfaction survey carried out by the home was in 2012.(512) [s. 85. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review and interview held with the DOC confirmed that the annual evaluation of the medication management system did not include the Medical Director, the Administrator, the pharmacy service provider and a registered dietitian, to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 116. (1)]

2. The licensee failed to ensure that the annual evaluation of the medication management system was conducted using an assessment instrument designed specifically for this purpose.

An interview with the DOC confirmed that the home is currently using the medication inspection protocol (IP) that is utilized by the Ministry of Health and Long Term Care (MOHLTC) for the purpose of the annual evaluation of the medication management system and not an instrument that is designed specifically for this purpose. [s. 116. (3)]

Issued on this 22nd day of August, 2014

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