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
Jun 27, 2014	2014_323130_0010	H-000753-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

LINHAVEN
403 Ontario Street, St. Catharines, ON, L2N-1L5

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), IRENE PASEL (510), KELLY HAYES (583), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 23, 24, 25, 26 and 27, 2014

Please Note: The following complaint and critical incident inspections were conducted simultaneously by Inspector Melody Gray: H-000484-14, H-000633-14, H-000743-14 and H-000596-14. The following non-compliance was issued as a result of these inspection and contained in this report. s.6(7), s.30(2), s.20(2)(f) and r.89(1)(a)(ii).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director Resident Care (DRC), Associate Director of Resident Care (ADRC), Resident Assessment Instrument (RAI) Coordinator, registered staff, personal support workers (PSW), health care aides(HCA), Food Services Supervisor, Registered Dietitian (RD), dietary staff, Manager of Housekeeping and Laundry, laundry staff, residents and families.

During the course of the inspection, the inspector(s) Interviewed staff, residents and families, reviewed clinical records, relevant policies and procedures, home's investigative records, minutes of meetings, employee records and observed care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

a) The Assessment Scoring Record for resident #110 indicated on an identified date in 2013, the resident had a pressure ulcer rating score (PURS) of 4, on another date in 2014, the PURS was 2 and on a later date in 2014, the PURS was 3. The plan of care reviewed on an identified date in 2014, indicated the PURS was 4. The DRC confirmed the plan of care was not based on the current assessment of the resident.

b) A review of resident #109's written plan of care, indicated the resident demonstrated specific responsive behaviours and that their Depression Rating Score (DRS) was 3/14 (a score of 3 or more indicated a possible depression). The plan of care also identified the goal would be to have a reduction in the resident's DRS score, through the review date. A review of the Outcome Summary Report for this resident on a specific date in 2014, identified that their DRS score was 1/14 and not 3/14 as identified on the resident's care plan. The DRC and RAI-Coordinator confirmed that the plan of care was not based on an assessment of the resident and their needs. (214)

c) A review of resident #102's plan of care indicated that the resident required a medium size brief. It was confirmed in an interview with psw's and through a review of

the ordered continence products records that resident #102 was provided and wore a small brief. The DRC confirmed the plan of care was not based on the resident's needs.(583) [s. 6. (2)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) The record of resident #600 indicated the resident was cognitively impaired and had specific responsive behaviours. Their plan of care indicated that they required the assistance of two staff to provide physical help for bathing because of these responsive behaviours. The home's record was reviewed and it was noted that on a specific date in 2014, the resident was bathed by one staff which resulted in resident to staff aggression. The DRC was interviewed and confirmed this information. The PSW who bathed resident #600 was interviewed and confirmed they had bathed the resident independently despite the plan of care direction that indicated two staff were required. [s. 6. (7)]

3. The licensee did not ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary.

a) A review of resident #109's written plan of care indicated that a specific mattress was required. On observation of the resident's bed system, it was identified that the resident did not have the specific mattress in place. An interview conducted with the RAI Coordinator confirmed that the resident did not have the specific mattress in place as the needs of the resident had changed. They confirmed that the resident`s written plan of care had not been updated to identify this change. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences, that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the Continence Care and Bowel Management program provided for assessment and reassessment instruments.

a) The RAI Coordinator and the Director of Resident Care confirmed the home does not have a clinically appropriate assessment instrument specifically designed for the assessment of continence, when required. [s. 48. (2) (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 Continence Care and Bowel Management program provides for assessment and reassessment instruments, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that each resident was offered a between-meal beverage in the morning.

a) Residents, staff and the Food Services Supervisor confirmed that not all residents on the "Brock" home area were offered a between-meal beverage in the morning. Staff interviewed on this unit stated they do not circulate the unit with a beverage cart at 1000 hours, as observed on other units. Residents residing on "Brock" are provided with beverages in the morning, only upon request. [s. 71. (3) (b)]

2. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.

a) On June 17, 2014, during the lunch service in the small and large Brock dining rooms residents were shown a food show plate with half a ham sandwich and sliced tomatoes. It was observed that residents were offered a half portion of the sandwich and those that chose the ham sandwich and sliced tomato option only received a half portion. In an interview with the personal support workers it was shared that residents who request more would receive another half sandwich. A review of the last three resident council minutes showed residents brought forward a concern that residents are not always offered seconds. The diet orders for residents on the Brock unit were reviewed and showed that no one was ordered half portions. An interview with the Registered Dietitian and Food Service Supervisor confirmed that residents should be offered a full portion and that the standardized recipes for sandwiches indicated the regular serving for sandwiches was a full sandwich. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a between-meal beverage in the morning and that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #4: 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 did not ensure that drugs were stored in an area or a medication cart that was secure and locked.

a) On June 25, 2014 at 1120 hours, the treatment cart was observed in the "Brock" home area hallway, outside the nurse's station. The cart was unsupervised and contained a variety of medicated treatments on top of the cart. Staff confirmed the treatments should not be accessible to cognitively impaired residents residing on the unit. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) A review of resident #402 and #403's clinical record indicated that they were offered and consented to immunization against influenza. A review of the physician's orders for these residents indicated that the physician had prescribed Flu Vaccine-Intramuscular (IM) and to give 0.5 ml IM annually with approved consent and as per direction of the Public Health Department. A review of the resident's clinical record and confirmation by the DRC, indicated that these residents had not been administered this prescribed medication. [s. 131. (2)]

2. The licensee did not ensure a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical, if, (a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; (b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and (c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

a) On June 23, 2014, registered staff advised that topical medications were administered by personal support workers (PSW) and that the topical medications, both prescribed and over the counter, were kept in a drawer at the nursing station. The PSW's interviewed confirmed that they apply topical medications and that they had not received education associated with the application of topical medications. The DRC confirmed that PSWs administer prescription and over the counter topical medications that are kept in the drawer at the nurse's station. The DRC stated that education was provided by the registered staff and staff sign off on the education. A random sample of sign off sheets for the last six PSW's hired was requested. The DRC reported that the last six PSW's hired had not signed off on the required HCA/PSW Topical Medication Application Skills Sheet. A copy of a blank skills sheet was provided which stated that each HCA/PSW must be observed in the applicaiton of topical medications by a registered nurse (RN) or registered practical nurse (RPN) three times in order to receive a certificate of completion. The home was unable to provide evidence of PSW education for application of topical medications. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

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 did not ensure that every resident had the right to be properly cared for in a manner consistent with his or her own rights.

a) Resident #102 was observed on two specific dates in 2014, with a foul body odour. It was observed on two other identified in 2014, that care was provided per the resident's plan of care. In an interview with the registered and non-registered staff, it was confirmed that resident #102 regularly had a strong body odour despite receiving two baths per week and routine continence care and routine bed linen changes. It was confirmed with the DRC and front line staff that the care provided as per the plan of care was not meeting the resident's needs. [s. 3. (1) 4.]

2. The licensee of a long-term care home did not ensure that every resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act.

a) On Monday June 23, 2014, the 0800 hour medication pass on "Secord" and "Merritt" home areas was observed. Registered staff on both home areas opened the unit dose medication packages and disposed of the packages, that contain personal health information (PHI), in the regular garbage on the medication cart. Both staff reported this is their usual practice and that the garbage from the medication cart is then discarded with other garbage on the unit. The registered staff on "Brock" was also interviewed and reported that they too disposed of the unit dose packaging containing PHI with regular garbage.
The DRC confirmed that staff discard unit dose wrappers containing PHI in the garbage. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents.

a) On June 26, 2014 at 1155 hours, an unlocked maintenance cart was observed unsupervised in the hallway next to the "Brock" unit where cognitively impaired residents reside. The cart contained a variety of sharp items and tools, including hazardous chemicals. This was verified with the DRC. [s. 5.]

WN #8: 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 did not ensure that any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

a) A review of the home's policy, Falls Prevention Program (MP00-002, dated June, 20, 2013) indicated that the home would complete the Ministry of Health and Long Term Care (MOHLTC) critical incident report if a fall resulted in the resident being transferred to hospital or admitted to the hospital. The Ontario Regulation 79/10 however, indicated that the licensee shall ensure that the Director is informed of an incident that caused injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition. [s. 8. (1) (a)]

2. 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 did not ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with. O. Reg. 79/10, s. 8 (1).

On June 23, 2014, a review of the medication practices in the home was undertaken. While reviewing the controlled substance disposal process with the DRC at 1100 hours, a stock narcotic count sheet for morphine 15mg/ml was observed to have one signature present on the outgoing staff line for the 1500 hour count. The registered staff present confirmed that this was their signature and they signed to save time at 1500 hours. The DRC confirmed that it is the home's expectation that outgoing and incoming staff count together at change of shift and when the count is confirmed, both staff sign the narcotic count sheet. Policy number PTH02-001 for Narcotics and Controlled Substances required the count be completed by two registered staff and that each registered staff was to ensure documentation was complete, including date, time, quantity of medication and signature. Staff did not comply with the home's policy for management of Narcotics and Controlled Substances.

b) The home's Skin and Wound Care policy (MP00-006) indicated that registered staff would make a referral to the Registered Dietitian (RD) for any break in skin, pressure ulcer or skin tear. The minimum data set (MDS) quarterly assessment completed on an identified date in 2014, for resident #110 identified seven stage one pressure areas. The RD confirmed they did not receive a referral from nursing to assess the resident.(130) [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) The home's policy Abuse and Neglect – Zero Tolerance (#RR00-001), indicated: 'Actions to be Taken by Staff Role and Responsibilities', the Administrator may be required to notify relevant Professional College if Applicable and determine the appropriate management action(s) to be taken as a result of the findings of investigation (e.g. education, discipline, policy revision, mandatory reporting to relevant professional college). The DRC confirmed the policy only included the consequences for those who abuse or neglect residents, for regulated staff and not for non regulated staff. [s. 20. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) On an identified date in 2014, an identified resident #601 with cognitive deficits/impairment who required staff assistance for incontinence care, reported to the home that the evening staff were neglectful and did not change their incontinence product and that their bed linen was not changed for 12 hours. According to the home's records and the resident's record registered staff checked on the resident during that time. The DRC was interviewed and confirmed that staff were required to change the resident's bed linen and provide continence care to the resident during the 12 hour period. The Personal Support Workers (PSWs) were interviewed and confirmed that they had provided continence care to the resident, but failed to document the care provided. [s. 30. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

a) A review of resident #102's bath schedule showed they were scheduled for tub baths on two specific days of the week. On an identified date in 2014, three days after their scheduled bath and on another date in 2014, two days after their scheduled bath, they were observed to have a foul body odour. Through interviews with non-registered staff and a review of the point of care records it was confirmed that tub baths were done as scheduled. Registered and non-registered staff confirmed that the resident's body odour only dissipated following a bath and that the current bathing schedule was not meeting the resident's hygiene requirements. [s. 33. (1)]

WN #12: 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 did not ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

a) The quarterly minimum data set assessment (MDS) completed for resident #115 on a specific date in 2013, indicated the resident had worsening bowel incontinence, the MDS assessment completed on a later date in 2013, indicated worsening bladder incontinence. The RAI Coordinator confirmed the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for continence, when the resident's continence status had changed. (130) [s. 51. (2) (a)]

WN #13: 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 did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. This information was verified by the President of the Residents' Council and the Administrator. [s. 85. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as a part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, procedures were developed and implemented to ensure that, residents' personal items and clothing were labeled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

a) The home's policies and procedures: Personal Clothing-Marking Residents' Personal Laundry items #E-1; Personal Clothing – Newly Admitted Resident # E-2 and Personal Clothing-Laundered Items Being Returned to the Units #E-6 were reviewed and they did not contain procedures to ensure that residents' personal items and clothing are labeled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

b) The home did not ensure that as a part of the organized program of laundry services, policies and procedures were developed and implemented to ensure that, residents' personal items and clothing were labeled within 48 hours of admission and of acquiring, in the case of new clothing. [s. 89. (1) (a) (ii)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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 did not ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

a) On two specific dates in 2014, a cart was observed outside a specific resident room. Registered staff stated it was an infection control cart and that that resident #400 was positive for a specific infection that required precautions. Staff acknowledged there should be a sign outside the room that advised what precautions should be taken. There was no sign present. Staff confirmed signage should be present outside the room. Seniors Services Policy and Procedure #IC05-008, indicated Contact Precaution signs were to be posted at the entrance of the resident's room. The DRC confirmed it was the home's expectation that signage be posted when infection control precautions were required. [s. 229. (4)]

2. The licensee did not ensure that screening measures were in place and residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

a) A review of resident #401, #402 and #403's clinical records indicated that the consent for immunizations had not included tetanus and diphtheria. An interview with the DRC confirmed that these residents had not been offered immunization against tetanus and diphtheria, in accordance with the publicly funded immunization schedules. [s. 229. (10) 3.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2013_214146_0043	130

Issued on this 15th day of July, 2014

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