Ministry of Health and Long Term Care: Inspection Reports Summary 2014

Report Date Type	Inspection Date(s) Inspection No.	Inspection Findings (summary)	Inspector(s) Orders
1. February 18, 2014 Follow up Inspection	January 30, 2014 2014 226192 0002	Findings of non-compliance (general requirements, documentation) (skin & wound care) WN #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 are documented. 1. A resident was sent to hospital for assessment and treatment. There was no documentation indicating when the resident returned or their status upon return. WN #2 The licensee failed to comply with skin and wound care. 1. There was no assessment of a resident's skin integrity at the time of return from the hospital.	Debora Saville **Compliance Order** 1. Documentation

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2. March 10, 2014 Complaint Inspection	January 30, February 18 & 20, 2014 2014 226192 0003	Findings of non-compliance (family council) (infection prevention & control) WN #1 The licensee failed to respond to Family Council, in writing within 10 days of receiving concerns or recommendations. WN #2 The license failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program. 1. Two residents presented with two or more upper respiratory symptoms within 48 hours, but only one was line-listed. No precautions were initiated and the presence of an outbreak as defined by the home's policy was not identified.	Debora Saville Christine McCarthy

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3. March 10, 2014 Critical Incident System Inspection	February 19, 2014 2014 226192 0006	No findings of non-compliance (pain)	Debora Saville
4. March 14, 2014 Critical Incident System Inspection	February 19 & 20, 2014 2014 226192 0005	Findings of non-compliance (prevention of abuse, neglect and retaliation) WN #1 Duty to protect The licensee failed to protect a resident from abuse and neglect by the licensee or staff in the home. Two residents were verbally abused by a staff member of the home and one of the two was neglected (staff failed to provide care). WN #2 Licensee must investigate, respond and act. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.	Debora Saville

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		WN #3 Reporting certain matters to Director The Director was not informed immediately of incidents of verbal abuse and neglect involving two residents and staff of the home. WN #4 Notification re incidents The licensee failed to notify a resident's substitute decision maker regarding an incident of verbal abuse.	
5. March 17, 2014 Complaint	February 19 & 20, 2014 2014 202165 0005	Findings of non-compliance (prevention of abuse, neglect and retaliation) WN #1 Nursing and personal support services The staffing plan failed to provide for a staffing mix that was consistent with residents' assessed care and safety needs. Residents became incontinent while waiting for call bells to be answered for toileting. A resident did not get a scheduled bath during the evening shift.	Tammy Szymanowski **Compliance order** 1. The home shall prepare, submit and implement a plan to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs that meets the requirements set out in the Act and this regulation specifically in the Puslinch Neighbourhood.

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		Call bells during evening shifts were not answered for extended periods of time: 1 hour 17 minutes, 1 hour 5 minutes, 51 minutes, 49 minutes, 1 hour 38 minutes, 1 hour 6 minutes. Two critical incidents in January 2014, during the evenings, confirmed the neglect of two residents. WN #2 Residents' Bill of Rights The licensee of the long term care home did not ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity was fully respected and promoted. WN #3 Additional staff training – direct care staff	

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6. April 23, 2014 Complaint	April 14 – 16, 2014 2014 226192 0012	Findings of non-compliance (Personal support services) WN #1 Policies and records The licensee failed to ensure that the home's policy on Weight and Height monitoring was complied with. A resident lost more than 2 kg in a given month and there was no request for a Dietary consult. WN #2 Plan of Care The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's needs changed.	Debora Saville
7. April 23, 2014 Follow up Inspection	April 14 – 16, 2014 2014 226192 0013	No findings of non-compliance (Falls prevention) (Hospitalization & change in condition)	Debora Saville

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8. April 24, 2014 Complaint	April 14, 15, 16 & 19, 2014 2014 226192 0011	Findings of non-compliance (dignity, choice & Privacy) (Personal Support Services) WN #1 Plan of Care A resident required treatment every two weeks to prevent recurrence of altered skin integrity. Medication administration sheets for specified months in 2013 and 2014 identified that the treatment was not signed for as being provided every two weeks. It was confirmed with staff that if the treatment was not signed for it was likely not provided. The resident was observed to have altered skin integrity. The resident did not always receive assistance with washing hard to reach areas, as stated in the plan of care. WN #2 Residents' Bill of Rights The licensee failed to ensure that Every resident has the right to participate fully in making any decision .... including any decision concerning his or her admission, discharge or transfer to or from a long term care	Debora Saville **Compliance Order** 1. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. The licensee shall ensure that the resident is provided care based on assessed need and documented in the plan of care.

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		home ..... Two residents sought to transfer to another long term care home and were discouraged by the home's management and/or doctor and no assistance was provided by the home. One resident and their substitute decision maker requested a change in physician (verbal and written requests) and no action was taken by the home's management.	
9. May 7, 2014 Critical Incident Inspection	May 2, 2014 2014 228172 0005	No findings of non-compliance (Responsive Behaviours)	Joan Woodley

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10. May 26, 2014 Resident Quality Inspection	April 22, 23, 24, 25, 29, 30 & May 1, 2, 5, 2014 2014 228172 0004	Findings of non-compliance (Nursing and Personal Support Services) (Plan of care) (Policies) (Accommodation Services) (General requirements) (skin & wound care) (Powers of residents' council) (Powers of Family council) (Satisfaction Survey) (Hazardous Substances) (Safe storage of drugs) (Security of drug supply) (Infection prevention and control) (Personal care) (Assistance dressing appropriately) (Residents' Council Assistant) (Food production) WN #1 The licensee has failed to comply with Nursing and Personal Support Services. The licensee has failed to ensure that the staffing plan provides for a staffing mix that is consistent with resident's assessed care and safety needs. A compliance order was previously issued on March 17,	Joan Woodley Dorothy Ginther Sally Ashby Sharon Perry Sherri Groulx **Compliance Order** 1. Staffing Plan The licensee shall implement the plan that was submitted related to the order previously issued on March 17 2014. The licensee has failed to ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

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		2014 with a compliance date of April ll, 2014. Residents interviewed stated that they can wait a long time for assistance with care. They thought the home was going to add more staff but this had not happened. Call bell logs indicated that call bells were not deactivated for 24 minutes, 19 minutes, 29 minutes, 19 minutes, 21 minutes. Job postings for an additional 8 hour PSW and a full time registered practical nurse were not posted until April 28, 2014. The order compliance date was April 11, 2014. WN #2 The licensee has failed to comply with plan of care. The licensee has failed to ensure the plan of care sets out clear direction for the staff and others who provide direct care to the resident. The licensee failed to ensure staff and others involve in different aspects of care collaborate with each other.	

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		WN #3 The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. Policy for Infection control sanitization/risk management. WN #4 The licensee has failed to comply with Accommodation services. 1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. Observations: rust stained toilet, soiled privacy curtains, toilet plunger beside toilet, yellowish soap build up on tile wall in shower room. 2. The licensee has failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. Observations: hairdryer plugged in above toilet & sink, thick layer of caulking on lower tiles, a wall patched around arm rail for the toilet (not finished or painted) and arm rail was loose, missing electrical outlet cover,	

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		end tables with scrapes, dents, scratches, walls with holes or gouges, stained ceiling tiles, unclean vent, broken tiles, missing paint & wallpaper in hallways WN #5 The licensee failed to comply with general requirements. Personal care and monitoring forms for residents had missing documentation. Medication order sheet had missing initials. WN #6 The licensee failed to comply with skin and wound care. The licensee failed to ensure that, at least weekly reassessments are completed on residents exhibiting altered skin integrity. WN #7 The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. The manager was unable to provide copies of written responses to issues and concerns	

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		raised by Residents' Council in the last three months. WN #8 The licensee has failed to respond in writing within 10 days of receiving Family Council's concerns or recommendations. WN #9 The licensee failed to comply with Satisfaction Survey. 1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey and in acting on its results. 2. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results. The Chair of Family Council was not aware of any satisfaction survey being completed in this home, so no input had been sought. This was confirmed by the interim General Manager. WN #10 The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.	

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		WN #11 1.The licensee failed to ensure that drugs are stored in an area that is used exclusively for drugs and drug-related supplies. (Urine sample in vaccine fridge.) 2. In a secured hone area, an open cardboard box containing prescription creams was on the floor of the nurses' station, no staff were present and residents were wandering about the nurses' station. 3. The licensee failed to ensure that controlled substances are stored in a double-locked area. (Lorazepam injectable in medication fridges) WN #12 The licensee failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use. Medication cart unlocked and unattended. WN #13 The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program. Observations: comb with hair on back of toilet, bar of soap on floor	

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		in shower, urinal hanging on grab bar near shower, bed pan on floor beside toilet, during lunch a server was not observed washing their hands, soiled privacy curtains, tub brush on floor, catheter bag hanging in bathroom with clamp on floor, large coffee cup still containing liquid beside towels and facecloths in tub room WN #14 The licensee failed to ensure the resident received individualized personal care, including hygiene care and grooming on a daily basis. WN #15 The licensee failed to ensure that a resident was dressed in their own appropriate, clean footwear. (resident's shoes encrusted with food debris) WN #16 The licensee failed to ensure that the appointed assistant to Residents' Council is acceptable to the council. The assistant is not always the same individual.	

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		WN #17 The licensee failed to comply with Food Production. The licensee failed to ensure that menu substitutions are documented on the production sheet.	
11. May 27, 2014 Complaint Inspection	May 16 & 20, 2014 2014 228172 0006	No findings of non-compliance (prevention of abuse, neglect & Retaliation)	Joan Woodley
12. May 27, 2014 Complaint Inspection	May 21, 2014 2014 228172 0007	Findings of non-compliance (Accommodation services – housekeeping) (Medication) (Nutrition and Hydration) (Pain) WN #1 Policies The licensee has failed to ensure that the policy Nutrition and Hydration is complied with. Chart reviews revealed omissions in documentation of food and fluid intake, between 23 to 34% of the time. Interviews with 2 PSWs revealed that they do not have time to complete the flow sheets. Registered Staff do not follow up with any omissions, so a 24 hour total is not possible.	Joan Woodley

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		The Registered Dietician revealed that Nursing staff are not completing individual meal totals or 24 hour totals.	
13. June 6, 2014 Critical Incident System	June 4, 2014 2014 183135 0041	No findings of non-compliance (prevention of abuse, neglect and retaliation) (Responsive Behaviours)	Bonnie MacDonald
14. June 12, 2014 Critical Incident System	June 4-5, 2014 2014 183135 0040	Findings of non-compliance (dignity, choice & privacy) (Prevention of abuse, neglect and retaliation) WN #1 Policies The licensee failed to ensure that the home's Criminal Record Check policy for hiring of employees was complied with. Record review revealed that the staff member did not provide the home with a Criminal Reference & Vulnerable Sector Screen (VSS) check within the 6 months of their hiring. At the time of hiring, the staff member also did not provide the home with a signed declaration disclosing any offence with which the person had been charged under the Criminal Code, as per the home's policy.	Bonnie MacDonald

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15. June 9, 2014 Complaint	June 5, 2014 2014 183135 0042	No findings of non-compliance (medication)	Bonnie MacDonald
16. July 24, 2014 Follow up	July 24, 2014 2014 258519 0022	No findings of non-compliance (Personal support services)	Sherri Groulx
17. August 5, 2014 Complaint	August 1, 2014 2014 271532 0026	Findings of non-compliance (Policy: Administration of Medication) WN #1 An inspector observed liquid medication and pills sitting in a medication cup on a resident's bedside table. The RPN confirmed that she had left the pills for the resident to take, but thought the liquid was from the previous day. The Student Practical Nurse confirmed she had not ensured that the liquid medication had been administered to the resident. The clinical record was signed, indicating that the medication had been given to the resident, when it had not. Staff should follow the home's policy and College of Nurses standards and not leave medication in a room unattended and not document medication as administered prior to administration to a resident.	Nuzhat Uddin