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	Debora Saville