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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2014	2014_323130_0018	H-000598-14	Resident Quality Inspection

Licensee/Titulaire de permis

ALBRIGHT GARDENS HOMES INC.
5050 Hillside Drive Beamsville ON L0R 1B2

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

ALBRIGHT GARDENS HOMES, INCORPORATED
5050 Hillside Drive Beamsville ON L0R 1B2

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

GILLIAN TRACEY (130), KELLY HAYES (583), ROSEANNE WESTERN (508)

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): September 3, 4, 5, 9, 10, 11, 12, 15, 16 and 17, 2014

Please note: The following inspections were conducted simultaneously with this RQI: H-003744-14 and H-0004530-14.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CFO), Director of Finance, business office staff, Chief Nursing Officer (CNO), Resident Assessment Instrument (RAI) Coordinator, Registered Staff, personal support workers, Director of Dietary Services, dietary staff, Manager of Program and Support Services, Volunteer Coordinator, Manager of Environmental Services, Resident Co-chair Person and Family Co-Chair Person, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

23 WN(s)
10 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A) On an identified date in 2014, visitors reported to the home that they overheard a staff member speaking with a raised voice to resident #105, in an inappropriate manner. The Chief Nursing Officer was interviewed and confirmed, that although the staff person was acting in a joking manner, the interaction between this staff person and resident #105 was inappropriate. The resident was not treated with courtesy and respect. (Inspector #508) [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) Resident #104 was receiving end-of-life care in 2014. A review of the resident's clinical records indicated that the resident had not had a bowel movement for 11 days. The home's medical directives directed registered staff to administer a suppository for constipation when a resident had not had a bowel movement for four days. It also directed staff that if the suppository was not effective after eight hours to administer a fleet enema. Resident #104 did not receive interventions according to the home's medical directives. The resident was not cared for in a manner consistent with their needs. (Inspector #508) [s. 3. (1) 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 every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and that every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #011's plan of care directed staff to toilet the resident upon rising in the morning (am), after breakfast, before lunch and after lunch, and to have the resident ring

and request a bedpan on afternoon and night shift. It also indicated that the resident wore an incontinent product, however, it also directed staff to change the resident's indwelling catheter monthly. The resident's clinical records indicated that the resident's catheter had been removed on an identified date in 2014. It was confirmed by registered staff that the resident's plan of care that staff refer to for direction did not set out clear directions. (Inspector #508)

B) The written plan of care for resident #100, developed by physiotherapy staff on an identified date in 2014, indicated the resident required two staff assistance for a standing pivot transfer. The written plan of care developed by nursing ten days later indicated the resident required two staff to provide weight bearing support to transfer with the sit to stand lift. The CNO confirmed the plan did not provide clear directions to staff. (Inspector #130) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) Skin assessments completed for resident #002 indicated on a specific date in 2013, the resident had a staged pressure ulcer to an identified area, which required treatment. On a specific date in 2014, registered staff identified impaired skin integrity to a specified area which had tested positive for a potentially contagious infection. Registered staff confirmed the written plan of care did not identify the affected areas, interventions or strategies to manage the wounds nor the need for infection prevention and control measures when it was required. (Inspector #130) [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A) Resident #100 was admitted to the home in 2014. The initial admission progress note indicated the resident arrived at the home in their own wheelchair; used a walker but most recently used a wheelchair. The initial admission assessment completed by registered staff the same day, indicated the resident required a walker for locomotion. The assessment completed by the physiotherapist during the dame time period indicated the resident was non ambulatory. Staff interviewed confirmed the resident was non ambulatory from the time of admission and that the assessments were not consistent with and did not complement each other with respect to mobility. (Inspector #130) [s. 6.

(4) (a)]

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

A) A review of the plan of care for resident #002 showed they were at high nutrition risk. Two interventions specified in the plan of care included; i) 60ml of Resource 2.0 at noon medication pass ii) monitor intake to ensure at least 75 percent of meal taken, if not offer extra supplement. An observation of resident #002 during the lunch meal on September 11, 2014 was completed. During the observation resident #002 did not receive any Resource 2.0 and resident #002 ate less than 25 percent of their meal and was not offered additional supplement. An interview with registered nursing staff confirmed resident #002 did not receive 60ml of Resource 2.0 as specified in the plan of care because the product was not available on the floor. In an interview with the nursing staff completed at the end of lunch service they confirmed resident #002 ate less than 75 percent and were not offered additional supplement as per the plan of care. (Inspector #583)

B) The physiotherapy plan of care for resident #100 developed in 2014, indicated the resident required two staff assistance for a standing pivot. The Point of Care (POC) records indicated the resident received one staff physical assistance for transfers. The Physiotherapist assessed the resident and confirmed the resident was non ambulatory. The RAI Coordinator confirmed the resident only used a wheelchair for locomotion, from the time of their admission, due to unsteadiness. Shortly after the resident sustained a fall with injury when one staff ambulated the resident with a walker from their bedroom to the shower. This information was confirmed by the PSW involved in the incident. (Inspector #130)

C) Resident #104 was identified as palliative and was receiving end-of-life care in 2014. A review of the resident's clinical records indicated that the resident had not had a bowel movement for 11 days. The home's medical directives directed registered staff to administer a suppository for constipation when a resident has not had a bowel movement for four days. It also directed staff that if the suppository was not effective after eight hours to administer a fleet enema. Resident #104 did not receive interventions according to the home's medical directives for their constipation for eleven days. It was confirmed by the Chief Nursing Officer that registered staff did not provide care to resident #104 as specified in the plan of care. [s. 6. (7)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) The Annual Minimum Data Set Assessment (MDS) completed in 2013, for resident #007, indicated the resident had mild pain daily. According to the Quarterly MDS Assessment completed sometime later in 2014, the resident's pain had worsened and they were now experiencing moderate pain daily. Registered staff were interviewed and confirmed that registered staff were required to complete a Non-triggered Resident Assessment Protocol (RAP) whenever the MDS coding indicated the presence of pain and that a pain RAP was not completed on the two identified dates. (Inspector #130) [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 sets out clear directions to staff and others who provide direct care to the resident, that the plan of care is based on an assessment of the resident and the resident's needs and preferences, that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, that care set out in the plan of care is provided as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. The home's policy N-9.16.1 indicated : Each resident will receive a formal pain assessment on admission, readmission, quarterly and with any significant change in health condition. RAI-MDS 2.0 assessment protocols and outputs will be reviewed in relation to pain and pain control with each new full assessment.

A) Resident #011 did not receive a quarterly, re-admission, significant change in health condition pain assessment or when their pain was not relieved by initial interventions. A review of the resident's clinical record indicated that the quarterly pain assessments had not be completed for three identified quarterly periods from 2013 to 2014. The resident had a change in condition in 2014, which resulted in the resident being transferred and admitted to hospital. Resident #011 was re-admitted to the home from the hospital on a specified date in 2014. The resident did not receive pain assessments as directed in the home's policy. It was confirmed by registered staff that resident #011 did not receive pain assessments as directed in the home's policy.(Inspector #508)

B) According to the clinical record for resident #007, the resident did not have a quarterly pain assessment completed on two occasions in 2013 and 2014. Registered staff confirmed the resident received a routine narcotic for pain management and did not consistently have a quarterly pain assessment completed. (Inspector #130)

C) According to the plan of care, resident #009, had pain management issues related to their diagnosis. The Registered staff confirmed a pain assessment had not been completed for a five month period in 2014.

D) Resident #100 was admitted to the home in 2014. Staff confirmed the resident did not have a pain assessment completed on admission or after sustaining an injury on an identified date 2014, when the resident was known to be experiencing pain related to their injury.

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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

A) The MDS Annual Assessment completed on an identified date in 2014, identified specific responsive behaviours. Registered staff were interviewed and confirmed the written plan of care did not identify any responsive behaviours, strategies or interventions to manage responsive behaviours. (Inspector #130) [s. 26. (3) 5.]

2. The licensee has failed to ensure that resident's plan of care was based on an interdisciplinary assessment that included the resident's health conditions including other special needs.

A) Resident #011 required a physician's ordered treatment intermittently for management of symptoms related to their diagnosis. During this inspection, the resident was observed on four occasions receiving this treatment. A review of the resident's plan of care which staff refer to for directions did not identify the resident's episodic symptoms nor the need for intermittent treatment. This information was confirmed by registered staff. (Inspector #508) [s. 26. (3) 10.]

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 responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) According to the clinical record of resident #002, on an identified date in 2013, staff identified open areas to a specific area. The area was assessed on a number of dates, however there were a number of identified weeks when the affected area was not reassessed. Staff confirmed the affected area was not reassessed weekly. (Inspector #130)

B) On an identified date in 2013, staff identified the resident had a staged ulcer. The affected area was not reassessed again for over two weeks, at which time staff identified the resident had open areas to a second area. There were no further reassessments found related to the open areas to the second identified area. Weekly skin assessments for the first staged area were not consistently completed by registered staff over a six month period from 2013 to 2014, at which time the area was noted to have worsened. Staff interviewed confirmed the affected area was not assessed weekly. (Inspector #130)

C) On an identified date in 2014, staff identified impaired skin integrity to an identified area. The area was assessed on three occasions in one week in 2014, at which time a culture confirmed the affected area to be positive for a potentially contagious infection. The area was reassessed on six occasions over the next two months then not again for almost three weeks. Staff interviewed confirmed the affected area was not assessed weekly. (Inspector #130) [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, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids were prepared, stored, and served using methods which prevented adulteration, contamination and food borne-illness.

A) On September 4, 2014, the snack and beverage cart on the third floor, was observed to contain uncovered pre-poured beverages. There was also a large basin on the cart that was filled with ice water and a plastic jug was observed to be immersed in the water. Staff confirmed this basin was used to fill water jugs at the residents' bedsides. Staff had direct hand contact with the fluid each time the jug was removed from the basin to fill water jugs. Registered staff interviewed confirmed this practice was unsanitary and had been brought to the attention of the Chief Nursing Officer (CNO) and the Director of Dietary Services prior to this inspection. The CEO and the CNO confirmed the fluids were not served using methods which prevented adulteration, contamination and food borne-illness. (Inspector #130) [s. 72. (3) (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 all food and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

A) The Installation And User's Instructions for a physical restraint indicated that the device had to be applied and fitted according to their directions at all times to prevent risk of injury. On September 4, 2014, residents #101 and #102 were observed with devices applied incorrectly. According to their clinical records, both residents were identified to be at risk for falls. Registered staff confirmed the belts were too loose. (Inspector #130) [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011's PASD was applied by staff in accordance with the manufacturer's instructions.

A) It was observed on September 15, 2014, that resident #011 was sitting in a wheelchair with a restraint applied incorrectly. It was confirmed by registered staff that the device was not applied according to the manufacturer's instructions. (Inspector #508) [s. 111. (2) (a),s. 111. (2) (b),s. 111. (2) (c)]

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 a personal assistive services device (PASD) used under section 33 of the Act, is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) On September 3, 2014, one unlabeled comb was observed in the tub room of Grapeview Unit, one soiled face cloth was observed at the bottom of the shower cabinet, used bar soap and one used disposable razor was observed in the common care basket in the tub room, the scrub brush used to wash the bath tub was observed on the floor and an unlabeled roll-on deodorant was observed in the tub room on Cedar Springs Unit. The tub stretcher/chair was noted to be covered in a white residue, there was an unlabeled urinary collection container observed on the counter in the shared washroom of Room 325-S, used bar soap was observed on the sink in the shared washroom in Room 327-S and an unlabeled fracture bed pan was observed on the washroom floor. An unlabeled urinary collection container was stored on the counter and back of the toilet in shared washroom of room 311-N. Staff confirmed that bar soap in soap dishes and roll-on deodorants should be labeled for individual use and urinary collection containers should be labeled and stored in a sanitary manner that prevents the spread of infection. (Inspector #130)

B) During a tour of the home on September 3, 2014, on Bruce Trail on 5th floor it was identified in the tub room that there were several items not labeled laying on a cart beside the tub which included, a roll on deodorant, scissors, tweezers, and a comb. (Inspector #508) [s. 229. (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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that quarterly itemized statements respecting money held by the licensee in trust for the residents were provided to residents or persons acting on behalf of a resident that included deposits, withdrawals and the balance of the resident's funds as of the date of the statement.

A) In an interview with resident #005's financial power of attorney it was shared that the home did not provide a quarterly statement of resident #005's trust account information. A review of the home's "Resident Trust Accounts" document (C-64), reviewed and revised January 2014, explained residents (or persons acting on behalf of residents) shall receive a quarterly report indicating current balance and transaction details (unless otherwise authorized), or more often if the account needs replenishing. In an interview with the Director of Finance on September 10, 2014, it was confirmed that the home did not provide quarterly itemized statements concerning residents trust accounts to the residents or persons acting on behalf of the residents. (Inspector #538) [s. 241. (7) (f)]

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 quarterly itemized statements respecting money held by the licensee in trust for the residents are provided to residents or persons acting on behalf of a resident that includes deposits, withdrawals and the balance of the resident's funds as of the date of the statement, to be implemented voluntarily.

WN #11: 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 has failed to ensure that the home was a safe environment for its residents.

A) On September 3, 2014 during a tour of the secure unit an open cart was observed on Two North, which contained multiple tools including a crowbar and a utility knife. Residents were observed in the hall where the cart was located, no staff or contractors were present. Upon the inspectors request the registered staff observed the cart and confirmed that it created an unsafe environment for the residents and removed the cart immediately. (Inspector #583)

B) On September 3, 2014, during a tour of the secure unit an open door to a utility room was identified on Two West. The utility room contained a lift and had cement walls, pipes and no windows. In an interview with the registered staff it was reported that this door locked automatically when closed and only maintenance had a key to open the door. The registered staff observed the open door and utility room and confirmed it created an unsafe environment for residents on the secure unit and that if a resident wandered in and closed the door it would be difficult for staff to find them and that staff on the unit would not have a key to open the door. (Inspector #583)[s. 5.]

WN #12: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) On an identified date in 2014, it was reported by visitors in the home that they overheard a staff member allegedly being abusive to resident #105. The incident was reported to the home by the visitors. The alleged incident was not verified, however, the Chief Nursing Officer confirmed that the staff member had been inappropriate towards the resident. The home did not comply with their policy to promote zero tolerance of abuse and neglect of residents when they failed to report an allegation of abuse. It was confirmed by the Chief Nursing Officer that the incident had not been reported to the Director and the policy to promote zero tolerance of abuse and neglect of residents was not complied with. (Inspector #508) [s. 20. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a 24-hour admission care plan was developed for each resident and communicated to direct staff within 24 hours of the resident's admission to the home and that at a minimum, the plan included any risks the resident may pose to himself or herself, including any risk of falling, and intervention to mitigate those risks.

A) Resident #100 was admitted to the home in 2014, at which time the resident was known to have an unsteady gait and be at risk for falls. The resident sustained a fall with injury within seven days of their admission. Staff confirmed the written plan of care did not identify the risk of falls or strategies to mitigate the risk until after the resident sustained a fall with injury. (Inspector #130) [s. 24. (2) 1.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations. 2007, c. 8, s. 33. (5).

Findings/Faits saillants :

1. The licensee failed to ensure that when a Personal Assistance Services Device (PASD) was used under subsection (3), the licensee failed to ensure that the PASD was used in accordance with requirements provided for in the regulations.

A) Resident #011 was observed wearing a PASD while up in their wheelchair. A review of the resident's clinical records indicated that: 1. Alternatives for the use of the resident's PASD had not been considered 2. The use of the PASD was not approved by a Physician, a registered nurse, a registered practical nurse, an Occupational Therapist, a Physiotherapist, or any other person provided in the regulations 3. The plan of care did not provide for everything required under subsection (5). An interview with the registered staff and PSW staff confirmed that resident #011 used the PASD while up in their wheelchair and that they did not meet all the requirements for use of a PASD under subsection (5). (Inspector #508) [s. 33. (5)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) Resident #001 was identified as a high risk for falls. Resident #001 had two falls in 2014. A review of the resident's clinical records indicated that the resident did not receive a post-fall assessment using a clinically appropriate assessment instrument after these falls. It was confirmed by registered staff that resident #001 did not receive a post fall assessment after their falls in 2014. (Inspector #508)

B) Resident #010 was identified as a high risk for falls and had a fall resulting in injuries in 2014. A review of the resident's clinical records indicated that a post-fall assessment using a clinically appropriate assessment instrument was not conducted after their fall. This information was confirmed by registered staff. (Inspector #508) [s. 49. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 was assessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain was not relieved by initial interventions.

A) Resident #011 was receiving regularly scheduled narcotics to manage chronic pain as well as a narcotic when necessary (PRN) for breakthrough pain. The PRN narcotic dosage was increased on an identified date in 2014, due to ongoing requests from resident #011 for the breakthrough narcotic. An assessment using a clinically appropriate assessment instrument was conducted in 2013 and in 2014. The resident did not receive an assessment when their pain was not relieved by initial interventions. It was confirmed by registered staff that resident #011 should have had a pain assessment using a clinically appropriate instrument designed for this purpose.(Inspector #508) [s. 52. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that all members of the Residents' Council were residents of the long-term care home.

A) A review of the Resident and Family Council meeting minutes attendance for March, April, May and June, 2014 showed that the home has one combined resident and family council that met together. In an interview with with the council assistant (Manager of Program and Support Services) it was confirmed that the Residents' and Family Council were combined and multiple family members were present during Residents' Council. It was confirmed that not all member s of the Residents' Council were residents. (Inspector #583) [s. 56. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided to Residents' Council within 10 days of receiving Resident Council advice related to concerns or recommendations.

A) Resident/Family Council minutes were reviewed for March, April, May, June, 2014 and showed that some concerns raised at council were not responded to until the following monthly meeting. In an interview with the family Co-Chairperson on September 13, 2014, it was shared that responses to concerns or recommendations by Resident/Family Council were provided immediately during council meetings or at the following monthly meeting for those concerns and recommendations that could not be responded to during council. In an interview with the Resident Co-Chair, it was confirmed that not all responses were provided to council in writing within 10 days of receiving Resident/Family Council advice. (Inspector #583) [s. 57. (2)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing was provided to Family Council within 10 days of receiving Family Council advice related to concerns or recommendations.

A) Resident/Family Council minutes were reviewed for March, April, May, June, 2014 and showed that some concerns raised at council were not responded too until the following monthly meeting. In an interview with the family co-chairperson on September 13, 2014 it was shared that responses to concerns or recommendations by Resident/Family Council were provided immediately during council meetings or at the following monthly meeting for those concerns and recommendations that could not be responded to during council. In an interview with the Resident/Family Council assistant (Manager of Program and Support Services) on September 16, 2014 it was confirmed that not all responses were provided to council in writing within 10 days of receiving Resident/Family Council advice. (Inspector #583) [s. 60. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures were implemented for addressing incidents of lingering offensive odours.

A) During an observation on September 3, 2014, of the tub/shower room located on Two South a lingering offensive odour was identified. A second observation was completed on September 10, 2014 of the tub/shower room located on Two South with the maintenance personnel. Maintenance personal confirmed there was a strong lingering offensive odour and shared it was a sewage odour coming from the floor drain located between the tub and shower which required cleaning. (Inspector #583) [s. 87. (2) (d)]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

A) On September 4, 2014, nursing staff were observed preparing the beverage carts for the afternoon nourishment pass, which included, preparing water, juices and snacks. Nursing staff were interviewed and confirmed the dietary department was not responsible for preparing the beverage and snack carts for residents. Personal support workers were required to prepare the beverage and snack carts in the morning, afternoon and evening. This information was confirmed with the CNO and Director of Dietary Services. (Inspector #130) [s. 101. (4)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to hospital.

A) Resident #100 sustained a fall with injury on an identified date in 2014. A mobile x-ray was taken in the home the next day and confirmed an injury. The resident was transferred to the hospital the same day and returned to the home the following day. The CNO confirmed the home did not report the incident to the Director when there had been a significant change in the resident's condition. (Inspector #130) [s. 107. (3)]

WN #23: 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 has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

A) It was observed that surplus controlled substances were stored in a single locked stationary cupboard, located in the locked treatment room. The CNO confirmed the stationary cupboard was not double locked as required. (Inspector #130) [s. 129. (1) (b)]

Issued on this 28th day of November, 2014

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

Original report signed by the inspector.