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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2014	2014_250511_0027	T-000003-14	Resident Quality Inspection

Licensee/Titulaire de permis

BAY HAVEN NURSING HOME INCORPORATED
499 HUME STREET COLLINGWOOD ON L9Y 4H8

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

BAY HAVEN NURSING HOME
499 HUME STREET COLLINGWOOD ON L9Y 4H8

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

ROBIN MACKIE (511), LEAH CURLE (585), VALERIE GOLDRUP (539)

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): November 17, 18, 19, 20, 21, 24, 25, 26, 2014.

Two Critical incident's were inspected at the time of the RQI. CI TI-T-14-001105 (CIS# 2657-000001-14) and TI-T-14-001442 (CIS# 2657-000004-14)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Clinical Nurse Manager, Director of Support Services, Food Service Supervisor, Activation Coordinator, Human Resources and Information Manager, Registered Nurse (RN), Registered Practical Nurse's (RPN's), Personal Support Workers (PSW's), dietary staff, housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

6 WN(s)
2 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. 6. Plan of care

Specifically failed to comply with the following:

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. (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 staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and (b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Resident #042 was admitted to the home in 2013 and had a history of falls as per the Community Care Access Centre (CCAC) MDS assessment documents. The CCAC admitting documents contained the Client Assessment Protocol (CAP) summary which identified falls as a triggered CAP and included a list of medications the resident was on that may contribute to a high risk for falls. The home's 72 hour Falls Risk Assessment, completed by the PSW's during the admission observation period, indicated the resident had episodes of unsteady gait in the same month of admission in 2013 which required the need for two-person assisted transfers. The Physiotherapist's initial assessment, completed in the same month in 2013, indicated the resident presented with a falls risk

and given the resident's cognitive decline the resident was unable to retain information learned to assist with safety. The Falls Risk Assessment document, completed by the registered staff in the same month in 2013, did not integrate the above CCAC assessment information and the resident was determined to be a low risk for falls. The assessment information completed by the Physiotherapist and the PSW's were completed during the same time period (within 24 hours) as the registered staff's Fall Risk assessment. The assessment information provided by the CCAC, the Physiotherapist, the PSW's and the registered staff were not integrated in order to identify or implement the resident's fall risk into the resident's plan of care. Interview with the DON confirmed resident #042 was a high risk for falls based on the interdisciplinary assessments and that the staff had not collaborated with each other to ensure their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee did not 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, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #042 was admitted to the home in a month in 2013 and sustained 3 falls in just over a 24 hour period. The last fall resulted in a resident injury that required hospitalization. The resident deceased the following month. A review of the resident's three day voiding diary, prior to the falls, indicated the resident was continent of their bladder and bowels. The resident's plan of care, prior to the falls, indicated the resident was able to wash their hands, adjust their clothing, clean their self and get on and off the toilet with only occasional assistance during the day. A falls incident summary report for the first fall indicated the resident was found on the floor in the washroom and had been identified as having lost their balance when trying to adjust their clothing and pull up their pants. A second fall incident summary report indicated the resident was found sitting on the floor of the bathroom, in front of the toilet, in a 'puddle' of urine and stool. The documentation further indicated the resident had been incontinent of urine and slipped when they tried to stand up off the toilet and that the resident had 'usually' been continent. A progress note indicated the resident had a large loose foul smelling bowel movement and the resident sustained the final fall when they were found on the floor of their bedroom and were crying out in pain. Vital signs were completed by the paramedics at the time of the transfer and the resident was noted to have a fever. The resident was sent to hospital and was treated for their injury. A review of the clinical documentation did not identify the resident was reassessed and interventions implemented in relation to their increased risk for falls or their change in bowel or bladder incontinence, as identified

in the clinical records, during the time of the multiple falls. Interview with the DON confirmed the resident's care needs changed, which resulted in an increased risk of falls, and the plan of care had not been revised. [s. 6. (10) (b)]

3. The licensee did not ensure the plan of care was reviewed and revised when the care set out in the plan for resident #032 had not been effective.

In a specific month in 2013, resident #032 was identified through their Minimum Data Set (MDS) assessment as having worsening incontinence from being occasionally incontinent to frequently incontinent of their bladder. Subsequent MDS assessments in specific months in 2013 and 2014, noted the resident to have frequent incontinence of bladder.

At the time of the inspection, the resident's plan of care included a goal, effective in a specific month in 2013, which stated, "will attempt to decrease frequency of urinary incontinence from frequently incontinent to occasionally incontinent by the next review date".
Resident Assessment Protocol (RAP) summaries, completed in a few different months in 2014, noted a different goal for the resident which was to maintain the resident's level of bladder continence. The resident's urinary voiding record was reviewed over 25 days in 2014, which identified the resident as being incontinent of bladder daily, with some control through the day. This was confirmed by unregulated health care staff working on the day and afternoon shifts. Registered staff confirmed the resident had frequent incontinence of bladder and the plan of care was not reviewed and revised when the care set out in the resident's plan of care was identified as being ineffective. (585) [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, (c) care set out in the plan has not been effective., to be implemented voluntarily.

WN #2: 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 home did not ensure that drugs, that were stored in a medication cart, were secured and locked.

A) On November 18, 2014 from 1130 to 1145 hours a treatment administration cart was observed in the hallway between rooms 29 and 31 with no registered staff in attendance. The cart was unlocked and drawers could be opened. Inside was a number of resident inhalers, eye drops and creams. Residents were observed to go by the cart from rooms 30 and 31. The Director of Care was directed to the cart and confirmed that the cart should be locked.(539)

B) During observation, on November 19 and 20, 2014, the medication cart was observed to be left unlocked, accessible to residents, and out of the view of the registered staff. Interview with the registered staff confirmed the medication cart should be secured and locked when not in view of the registered staff. (511) [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 ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secured and locked, to be implemented voluntarily.

WN #3: 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 home did not ensure that the following rights were fully respected and promoted: every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On November 17, 2014, during observation of the evening meal service at approximately 1750 hours, resident #19 was observed sitting in their wheelchair. The sides of the resident's hips and their incontinent brief was visible. The PSW proceeded to adjust the pants and confirmed that the expectation was for the resident to be properly clothed while up in their chair in the dining area. [s. 3. (1) 4.]

2. The licensee did not ensure that the following right of the resident was fully respected and promoted: 11. Every resident had the right to, iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On November 20, 2014, their were over 10 residents still remaining in the dining room at the end of the breakfast meal service. During this time, a PSW was overheard, in a loud voice, asking the other PSW to prepare a bedside breakfast tray to be delivered to resident #013. The PSW stated the resident's first and last name and then proceeded to state an intervention for that resident. Interview with the DOC confirmed the resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 was not kept confidential as other residents remained in the dining room and could hear the two PSW's conversation. [s. 3. (1) 11. iv.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On November 17, 2014, during the initial tour of the home, the east wing tub floor was observed to have worn anti-slip paint that was grainy in appearance with a 3 cm x 4 cm chip out of the floor. On November 25, 2014, the registered staff were asked if the need for floor repair had been added to the maintenance book as per the guidelines outlined in the home's document titled "Organized Program of Maintenance Services". They confirmed that the need for floor resurfacing was not logged in the maintenance book. The staff attended the tub area and confirmed that the floor was worn. The Director of Support Services confirmed that the anti-slip floor had become worn and required repair. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained at a minimum of 22 degrees Celsius.

On interview, two residents and one family member complained of being uncomfortable due to cold rooms within the home. Four resident bedrooms and and two common areas were inspected for temperatures below 22 degrees Celsius. One room, referred to by the home as the North West sitting room, was noted to be 21.6 degrees Celsius (C.) upon inspection on November 20, 2014. Interview with the Director of Support Service confirmed the room temperature was 21.6 C. and that the thermostat was set at 22 degrees Celsius allowing the temperature to fluctuate just below and above 22 degrees C. [s. 21.]

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was immediately informed of an outbreak of a reportable or communicable disease as defined in the Health Protection and Promotion Act.

On May 7, 2014, the home was declared in outbreak by Public Health. A Critical Incident Report was first submitted to the Ministry of Health and Long-Term Care by the licensee on May 15, 2014. This was confirmed by the Director of Nursing. [s. 107. (1) 5.]

Issued on this 3rd day of December, 2014

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

Original report signed by the inspector.