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

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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
Oct 15, 2015	2015_382596_0007	T-1743-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

THERESA BERDOE-YOUNG (596), JANET GROUX (606), JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23 and 24, 2015.

During the course of the inspection the following critical incident, complaint and follow up inspections were completed: T-1436-12, T2455-15, T-2073-15, T-2074-15, T-461-14, T-337-13, T-129-13.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer (CEO), Vice President Residential, Mental health & Cognition, Director of Care (DOC), Acting director of care (A)DOC, Manager of Environmental Services (MES), Director of Food and Nutrition Services (DFNS), Manager of Quality and Accreditation (MQA), Interim Manager Labour and employee relations, Advanced practice nurse (APN), Interim Unit Director, Social Worker (SW), Unit Directors (UD), Clinical Information Specialist (CIS), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary aides (DA), Assistant to DOC, Resident's Council President, Family Advisory Council President, residents and family members.

The following Inspection Protocols were used during this inspection:
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

14 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_405189_0003	596
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2014_405189_0003	596

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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's 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 is fully respected and promoted.

Record review for resident #012 revealed that unit director #126 was approached by the resident's family member related to an identified personal support worker's (PSW) conduct.
The home's investigation revealed that the identified PSW failed to adhere to the Residents' Bill of Rights by eating, taking breaks and storing his/her personal belongings in the resident's room.

Interview with the PSW and the unit director confirmed that the PSW conducted himself/herself in a manner that did not adhere to the Residents' Bill of Rights, and promote the resident's right to be treated with courtesy and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that residents' rights for his/her personal health information within the meaning of the Personal Health Information Protection Act, 2014 is kept confidential in accordance with the Act are fully respected and promoted.

On June 10, 2015, the inspector observed two registered staff discussing residents' personal health information during the shift report, in an open concept nursing station in the presence of two residents.
Interview with RPN #124 revealed that residents' personal health information was exchanged during the shift report in the nursing station, in the presence of two cognitively impaired residents. [s. 3. (1) 11. 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 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, and that residents' rights for his/her personal health information within the meaning of the Personal Health Information Protection Act, 2014 is kept confidential in accordance with the Act are fully respected and promoted, 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to

the resident.

Review of resident #008's clinical record revealed that he/she had a specified diagnosis and experienced associated symptoms. Resident receives an analgesic to relieve the pain.
Review of resident #008's plan of care revealed that it does not address resident's management of his/her pain.

Interview with RPN #143 revealed that resident has a specified diagnosis and verbalizes pain, and confirmed that this had not been care planned.

Interview with the (A)DOC revealed that the home's practice is any resident identified with pain must have a written plan of care addressing the pain, and confirmed that resident #008 did not. [s. 6. (1)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Record review of the PSW assignment sheet dated April 4, 2015, kept in a binder at the nursing station specifies residents' care needs and is used by PSWs to direct resident care. The assignment sheet indicated that an identified resident wears a medium brief. Review of the resident's plan of care indicated that resident wears a large brief.

On June 16, 2015, an interview with PSW #110 on the day shift revealed that he/she changed the resident using a medium brief, while interviews with two PSWs #112 and #113 on the evening shift revealed that the resident uses a large brief as the medium is too small. The two identified PSWs on the evening shift confirmed that resident #009's plan of care does not set out clear directions to staff. [s. 6. (1) (c)]

3. Record review of a critical incident report revealed that resident #025 had a fall on a specified date in June 2013, and sustained a fracture. Review of the resident's clinical record indicated that the resident was at risk for falls.

Interviews with PSW #123 and #161 revealed that resident used a floor sensor on the floor beside the bed as a falls prevention intervention for the past two years. The use of the floor sensor was not indicated in resident #025's plan of care. PSW #161 and registered practical nurse (RPN) #152 confirmed that the plan of care does not set out clear directions regarding the use of the floor sensor. [s. 6. (1) (c)]

4. Record review of resident #001's progress notes revealed that the resident had a fall in February 2015, and had verbalized on the fourth and fifth day after the fall about worsening pain aggravated by movement in specified areas. Record review of resident #001's plan of care dated February 18, 2015, revealed that the resident had pain related to specified medical conditions with the goal of providing adequate pain control by providing the following interventions: involve resident and family in decision making, assess and document pain using pain scales, give PRN medications per MD orders and document effects, administer pain medications as per MD order, and assess for constipation daily. The resident's plan of care did not indicate the location of where the resident was having pain.

Interview with PSW #173 revealed that resident #001 had pain that was relieved by applying topical cream and Tubigrip stockings. The PSW was not aware of any other pain sites or interventions.
Interview with an RPN #172 revealed that resident #001 had pain that is relieved by sitting in his/her chair to relax, and by administering analgesic. The RPN was unaware of any other pain sites or interventions. Interview with the acting director of care (A)DOC confirmed that all interventions to manage residents' pain must be listed in the plan of care. [s. 6. (1) (c)]

5. Review of an identified resident's written plan of care indicated that the resident wears medium sized liners and changes his/her own liner without reminders or coaching. Record review of the PSW assignment sheet dated March 2, 2015, indicated that the resident wears a large incontinent product and the toileting schedule is before and after meals, in the evening and as needed.

Interview with the identified resident indicated he/she was wearing pull-ups with a liner pad and changes the liner pad when he/she is incontinent of urine.
Interview with PSW #127 revealed that the resident is wearing pull-ups with a liner pad and he/she is mostly independent with toileting during the day.

Interview with RPN #128 revealed that the plan of care indicated the resident should wear medium size liners and the PSW assignment sheet indicated that the resident should wear a large brief. The PSW assignment sheet indicated the resident is on a toileting schedule since he/she needs reminders, and the written plan of care indicated that the resident changes his/her own liner without reminders.

RN #128 and unit manager #126 confirmed that the plan of care for the above mentioned identified resident does not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. Review of an identified resident's written plan of care dated April 8, 2015, indicated he/she wears medium pull-up or brief. Review of the resident PSW assignment revised May 13, 2015, indicated that resident wears large brief and requires toileting after lunch.

Interview with PSW #141 revealed that the resident wears a large brief and requires toileting assistance in the morning, after lunch and when the resident requests to be toileted.
Interview with RPN #142 and unit director #100 confirmed that the resident wears the large brief and the written plan of care related to the bladder incontinence section was not updated and did not set out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

7. On July 19, 2015, the inspector observed in resident #011's room a June 2015 schedule indicating the alternate days when the resident is getting up and staying in bed.

Review of an identified resident's skin integrity interventions in the written plan of care dated March 23, 2015, indicated to inspect areas of risk every shift, use pressure reduction and relief devices, keep skin dry and clean, maintain adequate nutrition and hydration and provide wound care as ordered. The written plan of care did not indicate when, at what time and for how long the resident should be sitting in the wheelchair.

Interview with RN #145 and #149 revealed that the resident is sitting up in his/her wheelchair every day for less than two hours on alternate days for lunch and dinner. The above mentioned registered staff revealed that the written plan of care does not set out clear direction to staff and others on which alternate time and day, and how long the resident should sit up in the wheelchair.

Interview with unit director #137 confirmed that resident #11's written plan of care does not provide clear direction related to when and for how long the resident should sit up in the wheelchair and/or stay in bed. [s. 6. (1) (c)]

8. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

Review of resident #002's progress notes during a three month period revealed the resident had pain to various areas of the body. When feeling unwell resident was given an ordered analgesic Q4hours, as well as another analgesic Q1h/PRN to manage the pain. Further review of the resident's clinical records revealed that the resident will let the staff know when he/she is having pain, and will identify to staff where the pain is.

Review of resident #002's plan of care dated May 11, 2015 revealed resident had pain related to medical conditions, and generalized pain with goals of providing adequate pain control with the following interventions: involve resident and family in decision making, assess and document pain using pain scales, give PRN medications per MD orders and document effects, administer pain medications per MD order, and assess for constipation daily.

Interviews with a PSW #174 revealed that the resident had pain but was not aware if the resident was currently still having pain.

Interview with PSW #181 revealed that resident has behaviours and not pain, and that he/she is not aware of the contents of the resident's care plan related to pain.

Interview with RPN #175 revealed that the resident has pain and will specify to staff where the pain is and request for pain medication. RPN #175 confirmed that not all staff were involved in the development and implementation of the plan of care. [s. 6. (4) (b)]

9. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the resident's plan of care and have convenient and immediate access to it.

Interviews with PSW #173 and RPN #172 revealed that the written plans of care for all residents are printed out and placed in the care plan binder in the nursing station accessible to all staff, and confirmed that resident #001's care plan was not included in the care plan binder and should have been. RPN #172 proceeded to print another copy of the resident's care plan and placed it in the binder. [s. 6. (8)]

10. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Record review of an identified resident's medication administration record (MAR) revealed missing signatures for the following medications:
-Acetaminophine 500mg tablet June 5 at 5:00 p.m., 9:00 p.m., and June 18, 2015 at 12:30 p.m;
-Divalproex sodium tablet on June 5 and 7 at 8:30 a.m., June 18 at 12:30 p.m. and June 5, 2015 at 9:00 p.m.;
-Gabapentin capsule on May 24, 25, 30, 31, June 7, 8, and 13, 2015 at 9:00 p.m.

Interview with RPN #182 revealed that staff missed signing the MAR on the above mentioned dates for the identified resident. [s. 6. (9) 1.]

11. The licensee has failed to ensure that 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.

Record review of resident #001's progress notes revealed that resident had a fall on a specified date in February 2015. Resident #001 verbalized on the fourth and fifth day after the fall that he/she was experiencing worsening pain aggravated by movement, related to the fall.

Record review of resident #001's plan of care dated February 18, 2015 revealed that resident had pain related to medical conditions, with the goal of providing adequate pain control by providing the following interventions: involve resident and family in decision making, assess and document pain using pain scales, give PRN medications per MD orders and document effects, administer pain medications as per MD order, and assess for constipation daily. The plan of care was not updated to reflect the new pain that resident was having after the fall on a specified date in February 2015.

Interview with RPN #172 revealed that residents' care plans are updated by the full time registered staff on a regular basis, when there is a change in the resident's condition. RPN #172 confirmed it was not reviewed and revised in response to resident #001's change in condition. [s. 6. (10) (b)]

12. Review of an identified resident's written plan of care dated May 16, 2015, indicated he/she has potential for impaired skin integrity related to incontinence and immobility.

Review of the resident's wound assessment dated May 20, 2015, indicated that he/she had an unstageable (stage X) pressure ulcer and a stage two pressure ulcer.

Interview with RPN #152 and unit director #126 confirmed that the resident's written plan of care was not updated when resident's wound care needs changed. [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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, that the staff and others involved in the different aspects of care of the resident collaborate with each other 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, that the following are documented: the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care, 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Review of resident #007's clinical record revealed that for a eight month period there were a total of 15 incidents of responsive behaviours towards other residents, staff and family members.

Review of resident #007's plan of care indicated when confrontation between the resident and others appear to be imminent in the lounge, the following interventions are to be provided:
-staff are to innocently inquire whether the resident is familiar with a particular song, offer ice cream as a distraction,
-immediately attend to his/her need/hunger in the dining room,
-spend 5-10 minutes with resident or talk about his/her past and family,
-administer medication as ordered, in a timely fashion.

Review of resident #007's progress notes revealed that the above mentioned interventions were ineffective and/or not implemented.
-On three specified dates in March 2014, resident #007 exhibited responsive behaviours towards staff and residents, and staff experienced difficulty redirecting the resident. Also on specified dates in May, July and October 2014 the resident continued to exhibit responsive behaviours towards staff and residents, where staff were unable to redirect the resident, and on one occassion the staff had to call building security.

Interview with RPN #119 and #138 revealed that there are interventions staff used to manage resident #007's responsive behaviours that are not in the plan of care and should have been, such as:
-avoid using the lounge door to enter the dining room to avoid passing in front of resident while he/she is watching television,
-avoid standing behind resident when in the dining room,
-position resident when sitting where he/she is able to observe the surroundings,
-allow resident to sleep around 8:30 a.m.,
-reduce noise around resident such as loud talking and coughing, and
-approach resident in a nice manner, provide compliments and engage in conversation during care.

Interviews with RPN #132 and PSW #156 revealed that resident's responsive behaviours were not
always prevented because the interventions were not always followed by others. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection- Residents' Bill of Rights and prevention of abuse and neglect at times or at intervals provided for in the regulation.

Review of the home's staff training records for Residents' Bill of Rights and interview with unit director #100 indicated that 12 per cent of staff did not receive training in Residents' Bill of Rights in 2014. Interview with PSW #139 revealed that he/she did not remember participating in the Resident's Bill of Rights training in 2014. [s. 76. (4)]

2. Record review of the home's training records and interview with unit director #100 revealed that 12 per cent of staff did not receive training on prevention of abuse and neglect of residents in 2014. [s. 76. (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 the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection- Residents' Bill of Rights and prevention of abuse and neglect at times or at intervals provided for in the regulation, to be implemented voluntarily.

WN #5: 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 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 is complied with.

Review of the home's policy entitled Prevention, Assessment and Management of Pressure Ulcers revised November 2014, indicated that for resident with existing ulcers, a comprehensive assessment (including local wound assessment) will be performed initially, followed by a reassessment at a minimum of weekly to determine wound progress and effectiveness of treatment plan. The assessment for resident with pressure ulcers must indicate the following:
i) Location
ii) Size- including length, width, depth, surface area
iii) Odour
iv) Undermining/tunneling/sinus tracts
v) Exudate
vi) Appearance of wound bed
vii) Condition of the surrounding skin and wound edges
viii) Pain

Review of resident #11's wound size that included the length, width, depth, and surface area within the home's clinically appropriate assessment tool that is specifically designed for skin and wound assessment, had not been documented for two weeks in November and three weeks in December 2014. It had not been documented for seventeen weeks during a six month time frame from January to June 2015.

Interview with RN #149 revealed that the resident's wound measurement was not completed for twenty two weeks during the above mentioned specified months, and the wound continued to progress.
Interview with interim unit director #137 confirmed the assessment for the resident's pressure ulcers did not include a weekly measurement as indicated in the policy. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Review of an identified resident's clinical record revealed the resident reported to an identified RPN on a specified date in July 2012, that he/she was awakened in the middle of the night, the bed covers were yanked off and he/she was treated very roughly. The resident alleged that a staff member was physically aggressive towards the identified resident.

Review of the resident's clinical records revealed that the above mentioned RPN reported the incident of abuse to the unit manager #184 the same day that the resident reported it.

Interview with the (A)DOC revealed that the home's policy entitled Abuse and Neglect of Clients: Zero Tolerance reviewed on October 1, 2011 directs staff to immediately report to the director any incidents of abuse/neglect and that the incident above was not reported immediately. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

On June 15, 2015 the inspector observed resident #002 with one shoe on and one shoe off. The right foot great toe and second toe toenails appeared long. Record review of the resident's clinical records from March 8- June 15, 2015 did not include a referral for chiropody services to have his/her toenails cut.

Interview with the resident confirmed that he/she had reported to staff that her right foot toenails needed to be cut and were last cut two to three months ago. Interview with the Social Worker (SW) #108 and (A)DOC revealed that the last time the resident's toenails were cut by the chirpodist was on March 9, 2015, and an appointment had not been scheduled for the resident's toenails to be cut again. The SW and (A)DOC agreed that the resident's toenail needed to be cut, and cutting of the resident's toenails was not done by staff. They confirmed that a referral to the chiropodist was not completed and should have been, and proceeded to schedule an appointment for the resident as soon as possible. [s. 35. (1)]

WN #8: 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 the 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.

Record review of a Critical Incident revealed that resident #025 had a fall on a specified date in June 2013, sustained a fracture and was transferred to hospital on the same day. The resident returned to the home the following month.

Record review and interviews with the (A)DOC and unit director #126 confirmed that a post- fall assessment using the home's falls risk assessment was not completed after the resident fell in June 2013, and should have been. They confirmed that the expectation is that a falls risk assessment should be completed after every fall with change in condition. [s. 49. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's whistle blower's protection policy is posted.

During the initial tour on June 9, 2015, the inspector observed that the home's Whistle Blower's Protection Policy was not posted.

Interview with the Vice President residential mental health cognition #102 confirmed that the above mentioned policy was not posted, and proceeded to post it. [s. 79. (3) (p)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Record review revealed that in 2014 the home had not taken a survey of the families to measure satisfaction with the home and the care, services, programs and goods provided at the home. Interview with the Manager of Quality and Accreditation # and the Vice president of mental Health and cognition confirmed that a survey was not taken of families in 2014. [s. 85. (1)]

2. Record review and interviews with the Manager of Quality and Accreditation #109 and the Vice president of mental Health and cognition #102 revealed that there were no questions included in the resident satisfaction survey done in 2014, pertaining to programs provided in the home such as: continence care, falls prevention, physiotherapy and occupational therapy (OT) services. [s. 85. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of resident #13's clinical record revealed that the resident reported to RPN #143 on a specified date in July 2012, that he/she was awakened in the middle of the night, covers were yanked off, and he/she was treated very roughly. The resident alleged that a staff member was physically aggressive towards him/her.

Review of the resident's clinical records, the home's investigation notes, and interview with the (A)DOC revealed that the police was not notified of the incident of abuse and should have been. [s. 98.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.

The inspector observed the following:
-On June 18, 2015, at 10:13 a.m., at a nursing station on the third floor a medication cart was left unlocked and unattended, with a bottle of Lactulose on top of the cart.
-On June 19, 2015, at 1:16 p.m., at a nursing station on the third floor a medication cart was left unlocked and unattended.
-On June 23, 2015, at 9:55 a.m., at the nursing station on the sixth floor a medication cart was left unlocked and unattended, with a bottle of Lactulose on the top of the cart.

Interview with RPNs #175 and #138 revealed that they had forgotten to lock the medication cart and put the Lactulose away before leaving, and confirmed that the medication carts should be locked when unattended. [s. 130. 1.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home

Record review of a drug record book on a unit on the fifth floor revealed 70 missing and/or incomplete entries between the months of March 3, 2015 to June 18, 2015, such as the date and signature of when the drug was ordered and/or received.

Interview with RPN #182 revealed that the nurse ordering and receiving the medications should date and sign their signature in the drug record book and confirmed it was not completed. [s. 133.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure for the purposes of paragraph 6 of subsection 76 (7) of the Act, that annual skin and wound care training shall be provided to all staff who provide direct care to residents.

Interview with the DOC revealed that the skin and wound care training for 2014 was provided to staff that provided direct care to residents. DOC revealed that a staff attendance list was not completed during the skin and wound care training, and he/she can't confirm that 100 per cent of staff attended the training. [s. 221. (1) 2.]

Issued on this 24th day of November, 2015

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

Original report signed by the inspector.