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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 8, 2016	2016_321501_0018	027676-16	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

BENDALE ACRES
2920 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 2T8

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600), IVY LAM (646)

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 14, 15, 16, 19, 20, 21, 22 and 23, 2016.

Critical incident intake # 014270-16 related to falls prevention was inspected concurrently with this inspection and findings are found within this report. Complaint and critical incident intake #018634-16 related to plan of care was also inspected concurrently however findings are found within a separate report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, Director of Nursing (DON), Nurse Managers (NM), Building Services Manager (BSM), Social Workers (SW), Registered Physiotherapists (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides (PCA), Housekeeping Aides, Resident Services Manager (RSM), Resident Assessment Instrument (RAI) Coordinators, residents, physician, family members, Substitute Decision Makers (SDM), Family Council member and Residents' Council Vice-President.

During the course of the inspection, the inspectors conducted observations in home and resident areas, observation of care delivery processes including medication passes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

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

8 WN(s)
5 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. (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. (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

This inspection had been initiated in response to a Critical Incident Report submitted by the home on an identified date, related to falls prevention for resident #040, who passed away on an identified date, from complications related to a fracture.

Review of the home's Resident Incident Report, revealed that RPN #124 found the resident on the floor in his/her room at an identified time. Upon assessment, resident #040 told RPN#124 that he/she had fallen off the bed to the floor while trying to get an item from the floor. Abrasions were noted to identified body areas, and the incident was noted in the physician's book.

Review of progress notes revealed that on an identified date, the resident was noticed to have decreased level of consciousness and complained of pain, and was sent to the hospital. The resident returned to the long-term care home on an identified date. Review of the hospital discharge summary, revealed that the resident had a fracture.

Review of the resident's care plan in place prior to the fall revealed that his/her falls interventions included: 'Keep adjustable bed in the lowest position for safe transfers, encourage and remind resident to ask for assistance with difficult tasks, and call bell placed to be within easy reach.' The resident's falls interventions did not include interventions specific to his/her risk of falls from picking up items from off the floor.

Interview with RPN-BSO # 109 revealed BSO had been involved in the assessment of the resident prior to this incident, and that he/she was aware that resident #040 liked to put an identified item on the floor under the bed. Further interviews with PCA #130, RPN-BSO #109 and RPN #112 revealed that they were aware that it was the resident's habit to pick identified items from the floor. RPN-BSO #109 and RPN #112 confirmed that resident was at risk of falling when he/she tried to pick things up from the floor.

Interviews with PCA #130, RPN #112, RPN #124 revealed that the staff provided resident #040 with a side table to place identified items on as a fall prevention intervention. Interviews with PCA #130, RPN #124, and RPN #112 revealed that this side table was an overbed side table that was not a normal fixture of the resident's room. Interview with RPN-BSO #109 revealed that he/she was aware that the resident had a side table, but he/she did not know that this was an intervention for the resident.

Interview with RPN #112 and NM #105 revealed that the care plan for falls risk is updated by the registered staff, and interdisciplinary staff. RPN #112 confirmed that the side table was not included as part of the resident's written plan of care. He/she further revealed that it was expected for the side table to be put in the resident's care plan as part of the resident's high risk for falls interventions.

NM #105 revealed that he/she was unaware that staff provided a side table for the resident as a fall intervention to prevent him/her from falls when he/she reached for things on the floor, and confirmed that the side table was not included as part of the resident's written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Interview with resident #003's SDM revealed the resident was often put in an incontinent product that made it difficult for him/her to toilet him/herself independently during the day. The SDM was also not convinced that resident #003 actually needed any incontinent

product during the day.

Review of resident #003's most recent plan of care revealed the resident only wore an incontinent product at night for bowel and bladder incontinence. Review of Multidisciplinary Data Set (MDS) assessments completed on an identified date, revealed resident #003 was continent of bowel but the assessment on an another identified date, revealed the resident was occasionally incontinent.

Interview with RN #100 and RPN #101 revealed resident #003 had become more incontinent recently and the SDM had been unwilling to consent to any incontinent products during the day. However, just recently, the SDM had agreed to using a specific type of incontinent product during the day. The registered staff admitted that a continence assessment had not been completed since resident #003's admission and his/her needs had changed. The staff confirmed the resident uses an incontinent product during the day and the plan of care had not been reviewed and revised.

Interview with NM #105 confirmed resident #003's continence care needs had changed and the resident had not been reassessed and the plan of care had not been reviewed and revised. [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 clear directions to staff and others who provide direct care to the resident and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a restraint by a physical device was included in the plan of care.

Observations on four identified days, revealed resident #008 was in a tilted position in a wheelchair.

Review of a Multidisciplinary Data Set (MDS) assessment completed on an identified date, revealed restraints were not used for resident #008. Review of the most recent plan of care revealed resident #008 is at risk for falls and two staff must assist him/her with transfer as he/she is unsteady and weak. One of the interventions to prevent falls was to place the resident in front of the nursing station where he/she can be seen at all times as he/she gets quite restless at times and tries to get up from the chair. There was no mention of tilting the resident's wheelchair in the plan of care.

Interview with PCA #131 revealed he/she tilted resident #008's wheelchair to prevent him/her from falling as the resident has a tendency to lean forward. PCA #133 admitted he/she was not aware if this was in his/her plan of care.

Interview with Nurse Manager #113 indicated tilting resident #008's wheelchair was a form of restraint. The NM confirmed that resident #008 had not been assessed to need this restraint and therefore was not included in the plan of care. [s. 31. (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 a restraint by a physical device was included in the plan of care, to be implemented voluntarily.

WN #3: 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 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.

This inspection was initiated in response to a CIS submitted by the home on an identified date, related to falls prevention for resident #040, who passed away on an identified date, from complications related to his/her fracture.

Review of the home's Resident Incident Report revealed resident #040 sustained a fall on an identified date. Resident #040 was found by staff sitting on the floor and leaning on the chair in the dining room while he/she was eating. Resident #040 was assessed and it was determined that there was no injury. Review of the Resident Incident Report package revealed that the Post Fall Assessment Huddle was not completed.

Review of the 'High Risk for Falls' section in the documented plan of care, revealed that resident #040 was at a high risk for falls having had an identified number of falls in 2015. Interventions included having staff complete incident reports and post fall huddle. The plan of care further directed the staff to document in the progress notes.

Review of Home's Falls Prevention and Management policy (Resident Care RC-0518-21. Section 05 - Resident Planning Process, published 01-08-2016), revealed that: All residents who have fallen require an interdisciplinary team assessment to clearly understand the contributing factors and appropriate interventions to prevent future falls. A "Post Fall Assessment Huddle" shall be completed after each fall prior to the end of the

shift. Any risk contributing factors identified shall be followed up by the nurse.

Post Fall Management included:
- RN or RPN to conduct a Post Fall Assessment Huddle meeting with the interdisciplinary Care Team present on the unit at the time of the fall. Identify root causes for the fall and preventative strategies for future fall and injury prevention.
- Document the meeting on the Post Fall Assessment Huddle Form
- As part of the Post Fall Assessment Huddle, review fall preventative strategies and modify plan of care when the evaluation of interventions demonstrates that the interventions are ineffective as indicated.
- When identified during the Post Fall Assessment Huddle, Physiotherapy to re-assess post-fall physical and functional status and identify interventions to improve/maintain or delay decline of physical functioning and strength
- RN or RPN to monitor implementation of preventative measures identified during the Post Fall Assessment Huddle.

Interview with the DON and NM #111 (Fall Lead), RPN #124, and RN #100 revealed that it was the home's expectation that the Post-Fall huddle is completed after each resident's fall.

Interview with RN #100 revealed that he/she had submitted the Resident Incident Report package. RN #100 stated that he/she is not sure why the Post-Fall Huddle for resident #040's fall on an identified date, was not completed in the package. Interview with NM #105 revealed that he/she had received this package but had not signed it as information was missing on the package, and had returned the package to the registered staff on the unit (RN #100). Physiotherapist (PT) #106 confirmed that he/she had not received a referral for the resident regarding this fall.

RN #100, NM #105 confirmed that they were not able to find a completed Post Fall Huddle for identified fall. NM #111 also confirmed that the Post-Fall Huddle was not completed and that the documentation was not complete for this incident. [s. 49. (2)]

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 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, to be implemented voluntarily.

WN #4: 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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes revealed a concern form was sent to the Building Service Manager (BSM) on June 2, 2016, regarding the brightness in the lounges in front of the elevators and requested the possibility of window coverings. The form asked for a response by June 12, 2016. The response date by the BSM was June 16, 2016.

Interview with the Resident Council Assistant confirmed the home had not responded to the Residents' Council within 10 days of receiving advice related to concerns or recommendations. [s. 57. (2)]

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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: 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 failed to ensure that staff participate in the implementation of the infection prevention and control program.

During the initial tour of the home, observations revealed that unlabelled care items including a personal soap dish, hair comb, plastic urinal, drinking glasses, mouthwash, dental floss, tooth brushes and tooth paste were stored in shared washrooms on the fourth, fifth and sixth floors. Further observation conducted on September 21, 2016, revealed that a linen cart with towels and briefs was left in a shared residents' washroom unattended.

Interviews with PCA #107, PCA #131, RPN #101, and RN #132 confirmed that the specific unlabelled items should be labelled in shared residents' washrooms. Interview with NM #113 (interim IPAC lead) revealed that the linen cart should not be stored in the resident's washroom as it is an unsanitary practice. NM #113 further confirmed that it is the home's expectation that items in residents' shared washrooms should be labelled and that linen carts should be kept in locked areas, such as the shower/tub room or the linen room when carts are not in use.

RPN #120 was observed by Inspector #600 to be unwell during an interview. Further interview with RPN #120 revealed that he/she was on medication for an infection. Interview with NM #113 confirmed that RPN #120 should not have been at work as he/she was unwell. NM #113 revealed that it is the home's expectation that staff who are feeling unwell should not come to work as they will put the residents at risk.

NM #113 confirmed that staff were not participating in the implementation of the infection prevention and control program. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. Review of the Residents' Council meeting minutes revealed the home had not sought the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. Interview with the Residents' Council Assistant and Administrator confirmed that the home had not sought the advice of the Residents' Council for the 2016 satisfaction survey. [s. 85. (3)]

WN #7: 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 has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Observations on September 15, 19 and 22, 2016, revealed a lingering urine odour in the shared washroom of an identified room.

Review of the home's policy #BS-0304-00 titled "Washrooms" revealed that if odours persist after cleaning and disinfecting, the housekeeper is to use a deodorizer.

Interview with housekeeping aide #110 revealed he/she was aware of the lingering urine odour in the washroom of an identified room and will often do extra cleaning in this room. He/she had not reported this issue to the Building Services Manager.

Interview with the Building Services Manager (BSM) revealed the home does not use a deodorizer to address lingering odours. Deodorizers are agents within their cleaning and disinfecting chemicals. Housekeeping aides should report to him/her if an odour persists so that more measures can be taken to address the problem. The BSM confirmed the home's policy and procedure should be updated to reflect this. [s. 87. (2) (d)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes the nature of each verbal or written complaint.

Interview with resident #005 indicated that he/she is uncomfortable ringing the bell and asking for assistance. Interview with one of the resident's SDMs revealed that a few months ago, resident #005 told him/her that when he/she rang the bell a PCA came to the room and stated, "turn off the bell."

Interview with the SDM revealed he/she had reported the above incident to Nurse Manager #113 who would know who the PCA was and indicated that the NM talked to all staff regarding the incident. Interview with the NM revealed he/she remembered the complaint. The NM explained that he/she never found out who the PCA was but did meet with all staff on all shifts to discuss the incident.

Further interview with the NM confirmed that he/she did not have any documentation of the above mentioned complaint. [s. 101. (2) (a)]

Issued on this 15th day of December, 2016

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

Original report signed by the inspector.