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 sions 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
Apr 12, 2016	2016_240506_0002	004308-16	Resident Quality Inspection

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD DUNDAS ON L9H 3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD DUNDAS ON L9H 3B7

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

LESLEY EDWARDS (506), CAROL POLCZ (156), CATHIE ROBITAILLE (536), MELODY GRAY (123)

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): February 22, 23, 25, 26, 29, March 1, 2 and 3, 2016.

Complaints

016505-15 – related to skin and wound care.
017986-15 – related to twenty-four hour nursing care.

009850-15 – related to skin and wound care.
030858-15 – related to menu planning.
032774-15 – related to care of residents, staffing concerns, complaints procedure and housekeeping.

Critical Incident Reports

009582-14 - related to fall prevention and management.
021116-15 - related to fall prevention and management.
032251-15 - related to fall prevention and management.

Follow-up Inspections

010653-15 – related to restraint application.
010656-15 – related to general requirements for programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Dietary and Environmental Manager, Medical Clerical Assistant, registered nursing staff, personal support workers (PSW's), Registered Dietitian (RD), dietary staff, laundry and housekeeping staff, recreation staff, Resident Assessment Instrument (RAI) Co-ordinator, maintenance staff, families and residents.

During the course of the inspection the inspectors toured the home, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures, staffing schedules and resident health records and conducted interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
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
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **8 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
O.Reg 79/10 s. 110. (1)	CO #002	2015_337581_0003	506
O.Reg 79/10 s. 30. (1)	CO #003	2015_337581_0003	506

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 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 failed to ensure that the policy and procedure for physician/prescriber orders were complied with.

The home's policy "Physician/Prescriber Orders, Clinical Procedures" (policy Number 11-06, last revised September 2010) indicated when registered staff were receiving telephone orders they were to: a. Clearly document the order on the Physician Order form provided by the pharmacy; b. Clearly identify that this is a telephone order; c. Read the order back to the physician; d. Date and sign with credentials the written order; e. The physician/ nurse practitioner was then responsible on their next day in the home to countersign the order written by the nurse.

During a review of resident #023's clinical record, the resident sustained a fall on an identified date in December 2014, and was sent to the hospital for assessment. The resident returned to the home with an order for pain medication. The next day the attending physician from the hospital called the registered staff and asked that the home complete a follow-up xray in house as the xray from the hospital could not verify an injury. There was no record that the staff member completed a physician order form. The xray was never completed at the home. The DOC confirmed that the staff member did not follow the home's policy regarding physician /prescribed orders. [s. 8. (1) (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 policies and procedures are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

An inspection was completed of the Registered Nurse (RN) staffing schedules between June 2015, and September 2015. The inspection noted that four shifts; on four different dates, that there was not at least one RN on duty and present in the home. This was confirmed by the Administrator. In November 2015, the home implemented a new staffing plan for RN's to address the number of unfilled RN shifts. (inspector #536) [s. 8. (3)]

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 registered nurse is on duty and present in the home at all times, to be implemented voluntarily.

WN #3: 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 :

The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair in relation to the following.

A. A lateral crack was observed across the entire length of the toilet tank cover in room an identified room.
B. The closet door in an identified room was observed to be completely off the over-head track and leaning forward into the closet.
C. A two foot by one foot piece of wood was missing from the interior bathroom door surface in an identified room.
D. The bathroom counter-top in an identified room, was observed to have an area of approximately six inches by two inches of missing linoleum exposing wood underneath.
E. In an identified room there was drywall missing from the lower corner of the closet door frame on the right side of wall at room entrance, exposing a piece of metal approximately three feet high by two inches wide which was not secured to the corner walls.
F. A six inch piece of flooring was observed missing across the entrance door area on the interior floor of the main elevator carriage with edge of the flooring material observed lifting in several areas.
The above observations were confirmed during a tour of these areas with the home's Environmental Services Manager(ESM) on an identified date in February 2016. (inspector #123)
G. During the initial tour of the home it was noted on the second floor in the shower room that the radiator was broken and a large rusted piece of the radiator was sticking out and could cause injury. The ESM confirmed that this could cause injury and was aware that the radiator was damaged and this was on the list to be fixed.
H. In an identified room there was a large hole in the wall near the baseboard. The ESM confirmed that they were unaware of the hole. These concerns were both repaired immediately due to risk of injury. (inspector #506)
I. During the kitchen tour performed by Inspector #156 and #506 on an identified date in February 2016, it was noted that the kitchen walls had large gauges out of them and were in need of repair. The "potato room", "storage/chest freezer room" and near the door to the garbage area in the kitchen had paint peeling off that easily fell off when touched and paint flakes fell onto food trays and into the potato bags. The walk-in freezer had a build up of frost on several bags of vegetables. Several plastic food pans were found to be melted along the sides and several metal ones were rusty along the edges. The kitchen area was not found to be maintained and in a safe condition and good state of repair. (inspector #156)[s. 15. (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 the home's furnishings and equipment are in a good state of repair, to be implemented voluntarily.

WN #4: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

The licensee failed to ensure that the use of a Personal Assistance Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if:
- Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Resident #015 was observed with a seat belt on while sitting in their wheelchair. The resident's record was reviewed and there was no documentation found to indicate that alternatives to the use of the PASD had been tried. The DOC was interviewed and confirmed that alternatives to the use of the PASD were not tried.
[s. 33. (4) 1.]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if:
- The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #007 was observed in a wheelchair with a table top on. The resident reported that they used the table top for activities of daily living. The resident's record was reviewed and documentation indicating that the resident or the substitute decision-maker of the resident consented to the use of the table top on wheelchair was not found. The registered staff #111 and DOC confirmed that a consent for the use of the table top was not available. [s. 33. (4) 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 use of PASD's alternatives have been considered, and tried where appropriate and consent has been obtained, to be implemented voluntarily.

WN #5: 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 failed to ensure that the resident who had fallen had a post fall assessment completed using a clinically appropriate assessment instrument that was specifically designed for falls.

A. In July 2015, resident #020 had an unwitnessed fall with injury, which resulted in a transfer to the hospital. A review of progress notes included a description of the event and the assessment of the resident with documentation of the injuries. The clinical record did not include a post fall assessment using a clinically appropriate assessment instrument. Interview with DOC confirmed that the resident did not receive a post fall assessment using a clinically appropriate assessment.

B. In September 2015, resident # 006 had a fall an unwitnessed fall with injury, which resulted in a transfer to the hospital. A review of progress notes included a description of the event and the assessment of the resident with documentation of the injuries. The clinical record did not include a post fall assessment using a clinically appropriate assessment instrument. Interview with the registered staff #106 confirmed that the resident did not receive as post fall assessment using a clinically appropriate instrument. [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 post fall assessments have been completed using a clinically appropriate assessment designed for falls, to be implemented voluntarily.

WN #6: 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 failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in March 2015, resident #021 had an identified area of altered skin integrity. This area required several courses of treatments with different methods. The area was not improving and was increasing in size and showing deterioration and a referral for an outside service was initiated. The DOC and documentation confirmed the resident's skin was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment from when the altered skin was identified. [s. 50. (2) (b) (i)]

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 residents with altered skin integrity have a skin assessment using a clinically appropriate assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The health record of resident #006 was reviewed including the resident assessment instrument-minimum data set assessment (RAI-MDS) and it was noted that the resident was fully incontinent of bowel. There was no documentation found in the resident's record that an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of continence on the resident's admission. Registered staff #107 confirmed that an assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not conducted. [s. 51. (2) (a)]

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 residents who are incontinent receive an assessment that includes casual factors, patterns, types of incontinence and potential to restore function with specific intervention using a clinically appropriate assessment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had and that the staff of the home complied with, (a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; (b) a cleaning schedule for all the equipment; and (c) a cleaning schedule for the food production, servery and dish washing areas.

A tour of the kitchen was performed by Inspector #156 and #506 on an identified date in February 2016. The kitchen area was found to be very dirty and in need of a deep cleaning. The floors, counters and walls had build up staining and splashes. The stove and oven area had built up food debris on the cooking area, the oven knobs and there were cobwebs found on the exhaust hood. Carts and shelving had built up food and were in need of cleaning. The soap dispenser located at the hand washing sink in the kitchen was empty and so was the hand sanitizer dispenser located at the kitchen door. It was noted that although there were some cleaning schedules located on clip boards, some dates/items were not completed and the schedule was not complied with for the kitchen area and food production areas. [s. 72. (7)]

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 policies and procedures for the safe operation and cleaning of equipment related to food production system and dining and snack services, to be implemented voluntarily.

WN #9: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #005 addressed their vision needs.

The RAI-MDS assessment and the resident assessment protocol (RAP) dated February 2016, indicated that the resident had a visual impairment. A plan of care was not in place to address the resident's visual impairment as indicated in the RAP. The DOC confirmed that this information should be in the resident's plan of care. [s. 26. (3) 4.]

2. The licensee has failed to ensure that the registered dietitian who was a member of the staff of the home completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition.

The progress notes for resident #007 were reviewed and it was noted that the resident had a medication change on an identified date in September 2015, resulting in the resident not responding and requiring assistance with feeding and activities of daily living. The progress note on an identified date in October 2015, indicated that the resident was positive for an infection. The significant change in the resident's condition was not assessed by the RD as confirmed with the Food Service Manager on an identified date in February 2016. [s. 26. (4) (a),s. 26. (4) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle included alternate choices of entrees, vegetables and desserts at lunch and dinner.

During the observed meal on an identified date in February 2016, it was noted that residents on a specific diet were not offered an alternative dessert. The home menu indicated that peaches and butterscotch pudding were to be provided to those on a regular diet; however, the menu cycle did not allow for an alternative choice of dessert for the residents on the specific diet. During the observed meal, two residents on specific diet were provided with peaches for dessert and were not provided with an alternative choice as confirmed with dietary aide #100 and the food service manager on an identified date in February 2016. [s. 71. (1) (c)]

WN #11: 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 failed to ensure that all staff received training related to skin and wound management.

The home's "Education Tracking Form" sheet provided by the home showed that only ten percent of the home's staff had received training related to skin and wound management in 2015. The DOC confirmed that not all staff received training in skin and wound management as it was not included in the mandatory training package. [s. 221. (1) 2.]

WN #12: 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 all staff participates in the implementation of the infection prevention and control program.

On an identified date in February 2016, during the initial tour of the home in the shower room on the second floor, two unlabelled and used zinc oxide containers and two used and unlabelled deodorant sticks were observed , as well as an unlabelled specimen container with a white powder substance which the PSW confirmed was zinc powder. This PSW #105 confirmed that all items should be labelled. [s. 229. (4)]

Issued on this 13th day of April, 2016

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

Original report signed by the inspector.