Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2014	2014_199161_0007	O-000141-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE GLEBE CENTRE INCORPORATED
950 BANK STREET, OTTAWA, ON, K1S-5G6

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

GLEBE CENTRE
950 BANK STREET, OTTAWA, ON, K1S-5G6

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

KATHLEEN SMID (161), ANANDRAJ NATARAJAN (573), JOANNE HENRIE (550), LISA KLUKE (547)

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): March 11 - March 14, 2014 and March 17 - 20, 2014

During the course of the inspection, the inspector(s) conducted a Critical Incident Inspection #O-000170-14

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Volunteers, a member of Residents' Council, President of Family Council, Pharmacist, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), a Dietary Aide, Coordinator Nursing Programs, Director of Care, Environmental Service Manager, Food Service Manager, RAI Coordinator, Registered Social Workers, Resident Activity Manager and the Executive Director.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines and schedules, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed two medication passes, observed several meal services, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (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).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA S.O. 2007, c.8, s. 6. (8) in that staff and others who provide direct care to a resident are not kept aware of the contents of the plan of care and given convenient and immediate access to it.

On March 14, 2014 Inspector #550 observed 7 out of 13 hard copies of resident's care

plans were not the most up to date copies of the care plans as evidenced by the following:

Resident #0025's hard copy care plan is dated November 2012. The most recent care plan in PointClickCare (PCC is) dated February 2014.

Resident # 0003's hard copy care plan is dated August 2013. The most recent care plan in PCC is dated March 2014.

Resident # 0004's hard copy care plan is dated March 2013. The most recent care plan in PCC is dated December 2013.

Resident # 0005's hard copy care plan is dated August 2012. The most recent care plan in PCC is dated February 2014.

Resident # 0006's hard copy care plan is dated August 2013. The most recent care plan in PCC is dated February 2014.

Resident #0007's hard copy care plan is dated June 2013. The most recent care plan in PCC is dated February 2013.

These observations were confirmed by Staff #106.

March 14, 2014 Staff # 123, #124 and # 106 told inspector #550 that PSW's do not have access to PCC and they access the hard copy of Resident care plans in the care plan binder located at the nursing station.

March 14, 2014 Staff #125 told inspector #550 that she did not know where the Resident care plans are kept and that they do not have access to PCC.

Mar 17, 2014 Inspector #550 observed Resident #8234's hard copy of care plan dated February 2013. The most recent care plan in PCC is dated February 2014. Staff #121 confirmed this is the most recent hard copy of the Resident's care plan. She told the inspector they do not print the paper copies of the care plans anymore, they use the copy in PCC. Staff #121 told inspector PSWs don't have access to PCC and that registered staff will look up on PCC the information they require and relay the information to the PSW's if needed. [s. 6. (8)]

2. On March 17, 2014 PSW's on the third floor indicated they refer to the hard copy of the Resident's care plans in the binders located at the nursing station. The care plans are available electronically in PCC however the PSW's do not have access to the electronic Resident files.

Resident # 8260 hard copy care plan is dated August 2012. The most recent care plan in PCC is dated December 2013. Interview with Staff #134 indicated that the hard copy of the care plans for the Residents are in these binders at the nursing stations for the PSW's, are to be kept up to date.

As such, staff and others who provide direct care to a resident are not provided the contents of the Resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that staff and others who provide direct care to Residents are kept aware of the contents of the plan of care and have immediate access to the most recent care plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.9 (2) 1 in that the licensee did not ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On March 11, 2014 the balcony door on the third floor was found unlocked and unsupervised. On March 12, 2014 the balcony door on the third and fifth floors were found unlocked and unsupervised.

On March 12, 2014 the Executive Director indicated to Inspector #161 that the home does not have a written policy that deals with when doors leading to secure outside areas such as balconies must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [s. 9. (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 there is a written policy that deals with when balcony doors must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, and that it is complied with, 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 :

1. The licensee has failed to comply with LTCHA, S.O. 2007, c.8, s. 15. (2)in that the home, furnishings and equipment are not clean nor maintained in a good state of repair.

On March 11, 2014 the Inspectors observed the following:

The 3rd floor central common area lounge window coverings and the lamp shades were stained. The drywall had holes and plaster showing.
The 5th floor dining room floor is scuffed. The central common area lounge has unpainted plaster on the wall. In the west lounge wooden chair legs are missing finish. The activity room floor had debris along the wall edges and the chairs have scuffed arms and legs.
The 6th floor dining room floor had debris along the wall edges and the legs of the stools. The window sills were dusty. The resident wooden chairs had missing finish on the chair arms and legs. The west lounge wooden chair and table legs are missing finish. The 4 tier plant stand was dusty and had debris on it and the 4 pink chairs are stained. The shower room walls are scraped with white plaster evident. [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 that that the home, furnishings and equipment are clean and maintained 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. 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).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident 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. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.31 (1), in that the licensee did not ensure that the restraining of three identified Residents is included in the Residents plan of care.

Throughout this inspection, Resident #8406 was observed to be seated in a wheelchair with a front closing lap belt fastened. Inspector #573 spoke to the Resident who stated that he/she could not undo the lap belt.

On March 17, 2014 Inspector #573 spoke with PSW #111 who provides direct care to Resident #8406. He indicated that this Resident does not have the ability to undo the front closing lap belt and that staff apply the lap belt because the Resident is at risk of falls due to unsteady gait.

On March 17, 2014 Inspector #573 spoke with PSW #128 who indicated that staff apply the front closing lap belt on Resident #8406 to prevent the Resident from falling.

Resident #8406's plan of care dated February 2014 did not include the use of a front closing lap belt as a restraint.

On March 14, 2014 Inspector #161 and #573 observed Resident #0025 sitting in a

wheelchair with a 4 point lap belt restraint. Inspector #573 spoke to the Resident who was unable to undo the restraint. The two straps which attach the lap belt restraint to the sides of the wheelchair were not in place. The lap belt was observed to be loose as evidenced by a greater than 4 finger width gap between the Resident waist and the lap belt. Inspector #573 spoke to PSW #111 and instructed him on the proper application of the 4 point lap belt restraint.

Resident #0025 plan of care in effect dated January 2014 did not include the use of a front closing lap belt as a restraint.

On March 14, 2014 Resident #8418 was observed sitting in a wheelchair with a front closing lap belt that was fastened. When Inspector #573 asked the Resident to undo the lap belt, the Resident did not respond to the question. PSW #111 indicated to the Inspector that Resident #8418 understands French better than English. The Inspector requested PSW #111 to ask the Resident in French, to undo his/her lap belt. The Resident was not able to undo the lap belt.

On Mar 14, 2014 Inspector #573 spoke with two PSW staff #111 and #129 who provide direct care to the resident. They indicated that the resident is not able to undo the front closing lap belt.

Resident #8418 plan of care dated March 2014 did not include the use of a front closing lap belt as a restraint. [s. 31. (1)]

2. The licensee has failed to comply with O. Reg 79/10 s. 110. (2) 1 in that the home applied a physical restraint without an order approved by a physician or a registered nurse in the extended class.

On March 14, 2014 Resident #8418 was observed in a wheelchair with a front closing lap belt that was fastened. When Inspector #573 asked the Resident to undo the lap belt, the Resident did not respond to the question. PSW #111 indicated to the Inspector that Resident #8418 understands French better than English. The Inspector requested PSW #111 to ask the Resident in French, to undo his/her lap belt. The Resident was not able to undo the lap belt.

On Mar 14, 2014 Inspector #573 spoke with two PSW staff #111 and #129 who provide direct care to the resident. They indicated that the resident is not able to undo the lap belt.

When inspector #573 asked Registered staff member #114 if there was a Physician's order for the lap belt restraint, the Registered staff member stated that the Resident "is not restrained. We don't consider his/her lap belt as a restraint since it's a Personal Assistive Safety Device - it protects him/her from falls."

Resident #8418 health care record was reviewed and there was no order written by either a Physician or Registered nurse in the extended class, for the application of the front closing lap belt restraint.

Throughout this inspection, Resident #8406 was observed to be seated in a wheelchair with a front closing lap belt fastened. Inspector #573 spoke to the Resident who stated that he/she could not undo the lap belt.

On March 17, 2014 Inspector #573 spoke with PSW #111 who provides direct care to Resident #8406. He/she indicated that this Resident does not have the ability to undo the front closing lap belt and that staff apply the lap belt because the Resident is at risk of falls due to unsteady gait.

On March 17, 2014 Inspector #573 spoke with PSW #128 who indicated that staff applies the front closing lap belt on Resident #8406 to prevent him/her from falling.

Resident #8406 health care record was reviewed and there was no order written by either a Physician or Registered nurse in the extended class, for the application of the front closing lap belt restraint. This was confirmed by Registered staff #116 who could not find an order for a front closing lap belt restraint in Resident #8406's health care record. [s. 31. (2) 4.]

3. The licensee has failed to comply with O. Reg 79/10 s.31 (2) 5 in that an identified Resident's plan of care does not include consent by the Resident or if the Resident is incapable, by the SDM for the use of physical device restraint.

On March 17, 2014 the health care record of Resident's #0025 was reviewed by Inspectors #573 and #161. There was no documentation of consent by either the Resident or their SDM for the application of the 4 point lap belt restraint. [s. 31. (2) 5.]

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 physician or a registered nurse in the extended class has ordered or approved the restraining; that consent by the Resident or if the Resident is incapable, by the SDM for the use of physical device restraint; as well as the restraining of the Residents, are included in the Residents plan of care., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 110. (1) 1 in that the home did not apply a physical device in accordance with the manufacturer's instructions.

On March 14, 2014 Inspector #161 and #573 observed Resident #0025 sitting in a wheelchair with a 4 point lap belt restraint. The two straps which attach the lap belt restraint to the sides of the wheelchair were not in place. The lap belt was also observed to be loose as evidenced by a greater than 4 finger width gap between the Resident waist and the lap belt. Inspector #573 spoke to PSW #111 and instructed him on the proper application of the 4 point lap belt restraint. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the 4 point front closing lap belt restraint for Resident #0025 is applied according to manufacturers instructions, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s 3(1)1, in that every licensee of a long-term care home shall 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.

On March 14, 2014 inspectors #161 and #573 knocked at the closed door to the semi-private room of Resident #8418 and were invited in by 2 the PSW's. Inspectors entered into the Resident's room and observed that the Resident was approximately 2 feet above the bed in a sling attached to a mechanical lift. The 2 PSW's were changing the continent product on the Resident without closing the privacy curtains. Inspector #161 closed the curtain for Resident #8418 privacy and dignity.

On March 17, 2014 @08:21 inspectors #161 and #573 observed Resident #0014 sitting in a chair next to the nursing station barefoot. At 08:25 a PSW proceeded to Resident #0014's room to obtain slippers which were then placed on Resident #0014's feet.

On March 18, 2014 @12:04 inspector #547 observed Resident #8217 and Resident #0026 receive their subcutaneous injection of a medication to their abdominal area while seated together at the nursing station before their lunch meal. [s. 3. (1) 1.]

WN #7: 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 comply with O. Reg. 79/10 s.8 (1)(b) 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 to be complied with, in that the home failed to ensure compliance with the following policy.

As per O.Reg79/10, s. 229(10)1 The licensee shall ensure that each Resident admitted to the home must be screened for tuberculosis within 14 days of admission and the documented results of this screening are available to the licensee.

Review of the home's policy titled TB Surveillance 3.03 Issue date 2008 provided by the Director of Care, indicates that "the RN/RPN will perform the second stage of the 2-step Mantoux and enter the data in the PointClickCare in the Immunization tab. The RN/RPN will read the results of the second test after 48 hours and record the results in PointClickCare.

There is no documentation in PointClickCare for Residents #0010, #0011 and #0012 regarding the administration nor results of the 2-step Mantoux. This was confirmed by the Director of Care.` [s. 8. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 r.17(1)(a) whereby the home is required to ensure a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

On March 12 and 18, 2014 the call bell cord in the bathroom of Resident #8400 was observed to be located in the corner near the wall to the left side of the toilet which was inaccessible to the Resident. On March 19, 2014 Resident #8400 indicated to the Inspector that the call bell cord cannot reached while seated on the toilet. The Resident indicated the need to wait until staff come back to take her/him off the toilet. This Resident could not recall ever being given the call bell cord while sitting on the toilet. [s. 17. (1) (a)]

2. On March 12 and 18, 2014 the call bell cord in the bathroom of Resident #8215 was observed wrapped around the right grab bar base that is in an up position that is not easily accessed for any resident, staff or visitor. When the Inspector pulled the call bell cord, the call bell did not activate. [s. 17. (1) (a)]

3. On March 12 and 20, 2014 the call bell cord in bathroom of Resident #8219 was observed wrapped around the right grab bar and when the Inspector pulled the call bell cord, the call bell did not activate. [s. 17. (1) (a)]

4. On March 12, 2014 the call bell cord in the bathroom of Resident #8260 was observed wrapped around the grab bar while in the upright position that is not accessible for the Resident to activate the call bell system.

On March 19, 2014 the call bell cord in the bathroom of Resident #8260 was observed wrapped around the left arm rest that is in an up position. When the Inspector pulled the call bell cord, the call bell did not activate. [s. 17. (1) (a)]

5. On March 12 and 19, 2014 @ 11:21 the call bell cord in the bathroom of Resident #8362 was observed to be too short in the resident's bathroom which was inaccessible to the Resident. [s. 17. (1) (a)]

6. On March 13, 2014 the call bell cord in the bathroom of Resident #8217's is wrapped around the right handrail beside the toilet. The call bell system was not activated when the cord was pulled.

Interview with Resident #8217 on March 18, 2014 indicated that when on the toilet, the Resident is not given a call bell cord, as there is none. Inspector #547 moved Resident #8217 near the toilet and showed the Resident the call bell cord. Resident #8217 indicated that they are not given the call bell cord when seated on the toilet and that the they have to wait until the staff come back to take the resident off the toilet.

Staff interview with the Director of Care on March 19, 2014 who indicated that the call system cord in the resident's bathrooms should never be tied off or wrapped to the handrails as either would prevent activating the call system for the staff to respond.

The home has not ensured that resident-staff communication response system to be accessible and used by residents, staff and visitors at all times in the resident's bathrooms. [s. 17. (1) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.29(1)b in that the licensee did not ensure that the written policy to minimize the restraining of Residents is complied with.

A review of the home's policy titled Minimal Restraint 08.06.01.1 issue date February 2013 provided by the Director of Care indicates the following:

A Physician's order to apply a physical restraint, consent from the resident/SDM, written in the plan of care and the identification of a Personal Assistance Services Device (PASD).

There were no Physician orders for front closing lap belt restraints that were observed on Residents #8406 and #8418.

There were no consents from the Residents or the SDMs for a front closing lap belt restraint for Residents #0025, #8406 and #8418.

There was no documentation in Resident's #0025, #8406 and #8418 plan of care regarding the use of a front closing lap belt restraint.

When Inspector #573 interviewed Registered staff member #114, she indicated that Resident #8418's front closing lap belt was a PASD used to prevent falls.

When Inspector #573 interviewed PSW #111 and #129, they indicated that Resident #8418's front closing lap belt was a PASD used to prevent falls

When Inspector #573 interviewed PSW #111 and #128, they indicated that Resident #8406's front closing lap belt was a PASD used to prevent falls. [s. 29. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 r.32 in that the licensee did not ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On March 17, 2014 on an identified unit the following was observed:

Resident #0014 and #0013 were unshaven;
Resident #0018 and #0017 hair was unclean and uncombed.

On March 19, 2014 on the same identified unit the following was observed:

Resident #0014 and #0013 were unshaven;
Resident #0018 hair was unclean and uncombed. [s. 32.]

WN #11: 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,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 in that the menu cycle is not reviewed by the Resident's Council.

Mar 13, 2014 during an interview with staff #135 told Inspector #550 the food and snack menu is not revised by the Residents' Council, it is being revised by the food committee. The minutes of the food committee are not shared with the Resident's Council.

Mar 20, 2014 staff member #136 told Inspector #550 that she reviewed the minutes of the Resident Council for the months of October, November and December of 2013 and was unable to find any documentation that the food and snack menu had been presented or discussed at the Resident Council. She confirmed the food and snack menu had not been presented to the Resident Council.

Mar 20, 2014 the Food Service Manager confirmed to Inspector #550 that the food and snack menu was not presented to the Resident Council.

Resident #0008 an active member of the Resident Council told inspector #550 during an interview the food and snack menu cycle is not reviewed by the Resident Council it is done by the Food Committee. [s. 71. (1) (f)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 73. (1) 1. in that the weekly menu is not communicated to residents.

On Mar 11 and 17, 2014 the inspectors observed on an identified unit that the weekly menu is not posted in an area that is visible to staff and residents. The weekly menu is posted inside the servery area, not accessible to residents or staff. This was confirmed by staff #110. [s. 73. (1) 1.]

2. The licensee failed to comply with O. Reg. 79/10 r. 73. (2) (a) in that staff members assist more than one or two residents at the same time who need total assistance with eating or drinking.

On March 17 and 18, 2014, at lunchtime, Inspector #161 observed one PSW feeding Residents #0018, #0020, #0017 and providing supervision to Resident #0019 at one table. At another table, one PSW was observed feeding Residents #0016, #0015 and #0013 and providing set-up help to Resident #0014 at another table.

On March 18, 2014 at lunchtime Inspector #161 observed one PSW feeding Residents #0021, #0022 and Resident #8418 at one table.

In the Resident's care plans it is documented the assistance required by staff at meal times. [s. 73. (2) (a)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(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. 78 (2)
(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. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.78 (2) (c) in that the licensee did not ensure the admission package includes the home's policy to promote zero tolerance of abuse and neglect of residents.

On March 17, 2014 the Registered Social Worker provided a copy of the home's Admission Package including the Resident and Family Handbook to Inspector #161. The Admission Package does not include the home's policy to promote zero tolerance of abuse and neglect of residents. The handbook states "a copy of the Glebe Centre's abuse policy can be requested through the unit nurse." [s. 78. (2) (c)]

WN #14: 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 comply with LTCHA 2007, S.O. 2007, c.8, s.79 (3)k in that the licensee did not post copies of the inspection reports from the past two years for the home.

On March 11, 2014 Inspector #573 observed that the license did not post copies of the inspections reports from the past two years.

On March 20, 2014 Inspector #547 observed that the license did not post copies of the inspections reports from the past two years.

On March 18, 2014 staff #122 indicated to Inspector #547 that the information is to be posted on the bulletin board located at the entrance to the home. [s. 79. (3) (k)]

WN #15: 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 comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (1) in that the licensee did not 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.

On March 13, 2014 Inspector #161 spoke with the Executive Director who indicated that the home has not conducted a survey of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home since 2011. [s. 85. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 r.136(6) in that the licensee does not ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Interview with Registered nursing Staff # 118 who showed inspector #547 the units' drug destruction box, where medications for disposal are placed in designated access restricted container kept in a separate area of the medication room that is kept locked as per the home's policy for Medication Management-8-01 named Drug Destruction and Disposal. In this designated access restricted container, the medications are not altered or denatured to such an extent that its consumption is rendered impossible or improbable.

the Registered nursing Staff #118 indicated that although staff cannot place their hands in this container, if this container is turned upside down, all of it's contents will fall out from the opening of this container.

On March 19, 2014 discussion with the Pharmacist for the home, who indicated that the medication destruction for non-controlled drugs is done with Stericycle, where they are incinerated off site. He indicated that the containers could be turned upside down and the medication sorted if someone was wanting to take any of these medications. He indicated that controlled medication is crushed and placed in a cup with soap and water before it is discarded as part of their practice for medication destruction. [s. 136. (6)]

WN #17: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 229 (10) 1 in that each resident admitted to the home was not screened for tuberculosis within 14 days of admission. The Director of Care indicated that the home performs a 2-step Mantoux to screen Residents for tuberculosis.

Resident #0010 was admitted to the home on a date in 2014. The first step of the 2-step Mantoux was administered several days later. The second step of the 2-step Mantoux was not done.

Resident # 0011 was admitted to the home on a date in 2013. The first step of the 2-step Mantoux was administered several days later. The second step of the 2-step Mantoux was done but no documentation of the result of the test.

Resident #0012 was admitted to the home on a date in 2013. The first step of the 2-step Mantoux was administered several days later. The second step of the 2-step Mantoux was done but no documentation of the result of the test.

On March 18, 2014 the Director of Care confirmed that Resident #0010 did not receive the second step of the 2-step Mantoux. She also confirmed there is no documentation regarding the results of the 2-step Mantoux for Resident's #0011 and #0012. [s. 229. (10) 1.]

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

Issued on this 21st day of March, 2014

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

Kathleen Smid ANANDRAJ NATARAJAN

Joanne Henric Lisa Kluke