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
Jan 26, 2017	2017_380593_0001	035417-16	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

GILLIAN CHAMBERLIN (593), JOANNE HENRIE (550)

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): January 9 - 13, 16 - 17, 2017.

In addition, one complaint was inspected during the inspection, log #035212-16, related to nursing and personal care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Manager Nursing Care Operations (MNCO), Registered Nursing Staff, Activation Staff, Housekeeping Staff, Maintenance Staff, Personal Support Workers (PSW), residents and family members.

The inspectors observed the provision of care and services to residents including a medication pass, staff to resident interactions, resident to resident interactions, residents' environment, resident health care records and reviewed licensee policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

5 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

During the initial home tour, January 9, 2017, Inspector #593 observed the doors to the soiled utility room (K140), clean utility room (K139) and linen chute (K137) to be unlocked on the Kentwood unit. It was observed that the door to the clean utility room was propped open with a washcloth.

During an interview with Inspector #593, January 9, 2017, PSW #103 reported that the doors to these areas on the Kentwood unit were to be kept closed and locked when not being used by staff. PSW #103 reported that these areas were non-residential.

During the initial home tour, January 9, 2017, Inspector #550 observed the doors on the sixth floor unit to be unlocked including the linen chute (W635), clean linen storage (W637) and Tel/data room (W657).

During an interview with Inspector #550, January 9, 2017, Environmental Services staff #111 reported that they left the door unlocked to the Tel/data room (W657) as they had been working in this room prior to the Inspector's tour, they also indicated that the door closure that pulls the door shut does not work properly and that he will fix it.

During the initial home tour, January 9, 2017, Inspector #550 observed the doors on the fifth floor unit to be unlocked including the clean utility room (T533) and clean linen room (T537).

During the initial home tour, January 9, 2017, Inspector #550 observed the door to the linen chute (Q435) on the fourth floor to be unlocked.

During the initial home tour, January 9, 2017, Inspector #550 observed the door to the servery on the third floor to be unlocked and opened. There were no staff members in this area at the time. During an interview with Inspector #550, January 9, 2017, RPN #112 indicated that the door to this area was supposed to be kept closed and locked as it was a non-residential area.

Observations by Inspector #593, January 16, 2017, on the sixth floor of the home found the doors to the linen chute (W635) and the soiled utility (W638) to be unlocked.

During an interview with Inspector #593, January 16, 2017, PSW #113 reported that these doors (W635 and W638) were supposed to lock automatically when they were closed. PSW #113 indicated that the doors to these rooms were to be closed and locked at all times when not in use as they were non-residential areas. PSW #113 checked the doors to both areas and reported that they needed to be fixed as they did not lock automatically unless pulled tightly shut.

Observations by Inspector #593, January 16, 2017, on the fourth floor of the home found the door to the linen chute (Q435) to be unlocked.

During an interview with Inspector #593, January 16, 2017, PSW #114 reported that the door to this area (Q435) did lock automatically however needed to be pulled tightly to lock. PSW #114 indicated that the door to this area was to be kept closed and locked when not in use as it was a non-residential area.

Observations by Inspector #593, January 16, 2017, on the Kentwood unit of the home found the door to the linen chute (K137) to be unlocked.

During an interview with Inspector #593, January 16, 2017, PSW #102 reported that the door to this area did lock automatically however needed to be slammed to lock properly. PSW #102 indicated that the door to this area was to be kept closed and locked when not in use as it was a non-residential area.

During an interview with Inspector #593, January 16, 2017, the DOC reported that it was the air pressure in these rooms that did not allow the doors to close firmly on their own, however staff were also supposed to check that the door has locked when they left the room and shut the door. The DOC indicated that the doors to the rooms found unlocked were non-residential areas and supposed to be locked when not in use. [s. 9. (1) 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 ensuring that all doors leading to non-residential areas are kept closed and locked when not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices are readily available in the home to meet the nursing and personal care needs of the residents.

This is specifically related to the availability of pagers for nursing staff, which are connected to the resident-staff communication and response system, which directly notifies nursing staff when a call for assistance has been made by a resident.

On January 10, 2017, Inspector #550 was on the first floor Kentwood unit and activated resident #009's call bell in the resident's room. It was observed that the light at the resident's bedroom door illuminated indicating that the call bell had been activated but there was no sound. PSW #102 came into the resident's room and told the inspector that the home uses a pager system to alert staff whenever a call is placed. The Inspector asked the PSW to see her pager to ensure that the call had been displayed on the pager and the PSW told the inspector that she did not have a pager as there were none available or working that morning. She further indicated that most pagers had not been working or been available for at least a week and a half.

During an interview with Inspector #550, January 10, 2017, PSW #103 indicated that she had a pager but it was not functional and the pagers on the unit had not been working

and available since before Christmas.

During an interview with Inspector #550, January 10, 2017, PSW #104 indicated that she did not have a pager as there were none available this morning.

During an interview with Inspector #550, January 10, 2017, PSW #105 indicated that he did not have a pager as there were no pagers available for him to take and that this had been going on for a while.

During an interview with Inspector #550, January 10, 2017, PSW #107 indicated to the inspector that she did not have a pager as the pagers were often missing or not working. She explained to the inspector that whenever a pager was not working, they were required to tell the on duty nurse. She indicated that the nurse today was aware that there were not enough pagers for all staff and that some were not working.

During an interview with Inspector #550, January 10, 2017, RPN staff #106 indicated to the inspector that she was not aware that there were pagers missing that morning. She stated that staff usually let her know when there were pagers not working or missing and she in turn informs the DOC but no one had yet to inform her that morning.

During an interview with Inspector #550, January 10 and 16, 2017, the Manager of Environmental Services indicated that he regularly had to order new pagers as they disappear or break. The pagers are replaced on an as needed basis and he usually orders extra pagers twice per year. The pagers were distributed so that every PSW on each unit has a pager and that the pagers were calibrated per unit by the company so they cannot be interchanged between units. When a pager was not functional the registered staff will call the DOC to obtain a replacement pager, as they are kept in her office.

During an interview with Inspector #550, January 16, 2017, the DOC indicated that she keeps the extra pagers in her office and when a pager was not functioning, the registered staff call her for a replacement pager. She stated to the inspector that she currently had two extra pagers for the 6th floor unit and one for the 4th floor unit in her office. She did not have any extra pagers for the 1st floor (Kentwood unit), the 2nd floor, 3rd floor and 5th floor units, if any pagers on these units were to be defective that day. The DOC indicated that maybe they should keep a larger inventory of extra pagers for each unit to ensure that pagers were always available to staff when they need to be replaced.

The licensee failed to ensure that pagers used as part of the resident-staff communication and response system were readily available at the home to meet the nursing and personal care needs of the residents. [s. 44.]

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 ensuring that supplies, specifically components of the resident-staff communication and response system are readily available at the home to meet the nursing and personal care needs of the residents, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. [Log #035212-16]

Resident #023 was admitted to the home with multiple diagnosis. The resident is alert and oriented.

Family member #115 sent an email to the licensee expressing concerns regarding the care of resident #023. One of their concerns was that not all staff were aware of the care requirements for resident #023 related to continence care needs when the resident was in bed and when the resident was up, this regular care was also required to prevent a specific condition from occurring. The complainant further indicated that the incidents

were usually related to staff that were not regular caregivers to resident #023 as reported by resident #023 and witnessed by themselves while visiting.

During an interview on January 16, 2017, family member #115 indicated to Inspector #593 that on a recent date, resident #023 informed them that the evening PSW did not provide continence care every hour as required when they were in bed. On two different dates, while visiting resident #023, family member #115 had to follow-up with the registered staff at 1630 hours as no one had come to provide continence care since the start of the evening shift at 1500 hours. Family member #115 further indicated that after the follow-up with the registered staff at 1630 hours, no staff came to provide continence care between 1830 hours and 2030 hours.

Inspector #550 reviewed resident #023's health care records and observed the following documentation in the resident's written plan of care under urinary incontinence:

• Continence care: Check by providing care every 2 hours

The documentation in Point of Care (POC) done by PSW under task, there was an assigned task for PSWs:
• Continence care every 1 hour
• Monitor urinary output

There was no specifications regarding the need to provide continence care every hour when the resident was in bed and every two hours when the resident was up.

During an interview on January 17, 2017, RPN #106 indicated to inspector #550 that PSWs are required to provide continence care every one to two hours. The Manager of Nursing Care Operations indicated to the inspector that the resident's continence care has to be provided every two hours. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled "Personal Assistive Service Devices (PASDs)", 08-06-02, as per O. Reg 79/10 s. 8 (1) (b), that any required plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As per O. Reg 79/10 s. 109 (e), every licensee of a long-term care home shall ensure that the written policy under section 29 of the Act deals with, (e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented.

A review of the home's policy titled "Personal Assistive Service Devices (PASDs)", 08-06 -02, dated April 28, 2011, found that the use of the PASD must be approved by one of the following: Physician, RN, RPN, or a member of the College of Occupational Therapists of Ontario or the College of Physiotherapists of Ontario. The prescribing clinician is required to obtain informed consent for the treatment from the resident and or the substitute decision-maker (SDM) and record informed consent. Documentation of PASD use must include authorization of the use of the device.

During the Inspection, resident #006 was observed in bed with bilateral bed rails in use and when up in their wheelchair, a safety device applied and the wheelchair in an altered position.

A review of resident #006's health care record found no documented approval for the use of the wheelchair in an altered position or consent for the use of the safety device, bilateral bed rails or wheelchair in an altered position.

During an interview with Inspector #593, January 13, 2017, RPN #109 reported that resident #006 used bilateral bed rails when in bed and a safety device and altered position when in their wheelchair and they are all considered PASDs. RPN #109 reported that for the use of the PASDs, they were required to receive a written order for their use as well as documented consent from the POA of the resident.

During an interview with Inspector #593, January 16, 2017, the DOC reported that there was no additional documentation related to the use of the PASDs for this resident. [s. 8. (1) (a)]

2. The licensee has failed to ensure as per O. Reg 79/10 s. 8 (1) (b), that any required plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with [Log #035212-16].

As per the LTCHA, 2007 s. 21, every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulation for initiating complaints to the licensee and for how the licensee deals with complaints.

A review of the home's policy titled "Concerns / Complaints", RC 8.04.01, last revised May 2015, found that for verbal and written complaints, a concerns/complaints form is completed and forward to the manager who can best respond to the concern or complaint. The Manager was then responsible for sending a copy of the complaint to the Administrator and then the completed document once the complaint has been addressed.

The home received two emails from family member #115 regarding the care issues described in the complaint received by the Director of the MOHLTC of resident #023. The first email addressed "major care concerns" and the second, informing the home that they have "lodged a formal complaint with the MOHLTC regarding the care concerns that have yet to be addressed".

During an interview with Inspector #593, January 17, 2017, the Manager of Nursing Care Operations (MNCO), reported that they did not complete the complaint / concern form as per the home's policy for the two complaints received by email.

During an interview with Inspector #593, January 17, 2017, the Administrator indicated that it was the expectation of the home that the complaint process documented in the home's policy was followed. [s. 8. (1) (b)]

WN #5: 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).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action; time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant [Log #035212-16].

During an interview with Inspector #593, January 16, 2017, family member #115 reported that they had previously reported several complaints to the home regarding resident #023’s care and was concerned as they felt that the home did not really take serious action until they informed them that they were submitting a complaint to the MOHLTC.

The home received two emails from family member #115 regarding the care issues described in the complaint received by the Director of the MOHLTC of resident #023. The first email addressed “major care concerns” and the second, informing the home that they have "lodged a formal complaint with the MOHLTC regarding the care concerns that have yet to be addressed".

During an interview with Inspector #593, January 17, 2017, the Manager of Nursing Care Operations (MNCO), reported that when receiving written or verbal complaints, they are not documenting the requirements as per the regulations and indicated that she does not have a written record for the two complaints received by email. [s. 101. (2)]

Issued on this 27th day of January, 2017

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

Original report signed by the inspector.