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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017	2017_631210_0018	024785-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

CAREFREE LODGE
306 FINCH AVENUE EAST NORTH YORK ON M2N 4S5

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

SLAVICA VUCKO (210), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30, 31, November 1, 2, 6, 7, 8, 9, 10, 2017

During the course of the inspection, the inspector(s) spoke with family members, residents, Administrator, Director of Care, Nurse Managers, registered nursing staff, personal care aids (PCAs), President of Residents' Council and Family Council. The inspectors observed the provisions of care, medication administration, and reviewed the resident' clinical record.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A review of resident #009's clinical records revealed the resident had altered skin integrity on specified body area on an identified date, that healed one month after it was identified. One month after the skin impairment healed, appeared again on the same body area and healed one month later.

A review of the written plan of care revealed interventions for preventing pressure and skin breakdown including staff to turn and reposition the resident every two hours and document on the Turning and Repositioning sheet every shift. A review of the Physiotherapist assessment and recommendations from an identified date, revealed the resident required frequent bed turning.

Interview with resident #009 revealed the resident is not able to turn and reposition by him/herself but he/she needs assistance by staff. He/She further indicated that staff do not turn and reposition him/her on sides consistently every two hours and that certain days when he/she is staying in bed he/she is in the same position for long periods and not repositioned for a whole day or night.

A review of resident #009's Turning and Repositioning Schedule Worksheet for the period of three months revealed no signatures during evening (in 60% of cases) and night shift for a period of two months, and no documentation at all for two months later. There was missing documentation during eight days in an identified month. The documentation in one month indicated the position of the resident (supine, right side or left side). The documentation in another month had initials from staff that the positioning was performed but the side of repositioning was not indicated.

Interview with registered staff #100 revealed when a resident is turned and repositioned it has to be documented in the Resident Turning/Positioning Schedule Worksheet indicating the side on which the resident was turned and confirmed that during the the above mentioned time periods the documentation was either missing or it was improperly documented. [s. 30. (2)]

2. A review of resident #005's clinical record revealed the resident had impaired skin integrity on an identified body area in a period of nine days. The resident was placed on turning and repositioning schedule every two hours in bed and wheelchair. A review of the Turning/Positioning Schedule Worksheet for the same period revealed no

documentation during day and night shifts. Interview with registered staff # 102 confirmed that it was not documented during the above mentioned periods. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

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

A review of resident #001's clinical record revealed the resident had an impaired skin integrity on an identified body area for an approximate period of one and a half months.

A review of Occupational Therapist (OT) assessment and recommendation from an identified date, revealed the resident was not to stay in the wheelchair for the whole day but for limited time. Physiotherapist assessed the resident on an identified date, and recommended interventions to prevent skin problems. He/she indicated he/she discussed with registered staff and PCAs about his recommendations but it was the nursing staff who should update the care plan and make sure the recommendations are implemented in practice.

A review of the written care plan for skin and wound care revealed interventions for prevention of skin ulcer including positioning and pressure relieving devices on bed and wheelchair, but no intervention for the time periods that the resident has to stay in the wheelchair and in bed. Interview with Personal Care Aid (PCA) revealed he/she puts resident #001 in bed after lunch during day shift, because he/she thought that it was good for the skin problems the resident had. Interview with PCA # 103 revealed he/she never puts resident #001 in bed during the day. The inspector observed resident #001 on November 5 and 6, 2017, at 1400 hours and the resident was in bed. According to registered staff RN #105 the PCAs know the routine of the resident and when he/she should go to bed.

Interview with registered staff #105 revealed the written plan of care was not updated with OT recommendations, and there was not clear direction to PCAs when and for how long resident #001 should be placed in bed in order to manage the impaired skin integrity. [s. 6. (1) (c)]

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the Medication management policy, MM-0106-00, Narcotic and Controlled Medications, dated April 01, 2016, revealed in the section for documentation and monitoring that following medication administration, registered staff to document in both the medication administration record and Combined Monitored Medication Record with Shift Count (Appendix A). At shift change, one nurse from the outgoing shift and another nurse from the oncoming shift, will count narcotics and controlled medications and document the count by utilizing the Combined Monitored Medication Record With Shift Count.

The section for Medication Administration revealed registered staff to not pre-pour medications. Medications must be administered immediately after preparation.

An observation on November 9, 2017 at 12:00 hrs revealed certain controlled medications (narcotics) were administered during the day shift to residents #010 and #011 and not signed at the moment of administration in the Monitored Medication Record. A review of the Combined Monitored Medication Record with Shift Count revealed the four narcotic medications were not signed at 0700 hrs during the shift exchange for identified residents.

Interview with registered staff RPN # 110 revealed he/she did not sign during the shift exchange count, and right after the narcotics administration. Interview with DOC confirmed that the policy Medication management, Narcotic and Controlled Medications was not complied with. [s. 8. (1) (b)]

WN #4: 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 has failed to ensure that, 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.

A review of resident #006's Minimum Data Set (MDS) assessment from two identified quarters, revealed that the resident's bladder continence status worsened into frequently incontinent.

A review of the resident's MDS assessment from two identified quarters, revealed that the resident's bowel continence changed from continent to usually continent.

A review of the resident's clinical record revealed the resident was admitted to the home on an identified date. The inspector found a blank form of Continence and Bowel Function Assessment (in 10 days since admission) in the chart. There was no assessment completed for the resident's continence care and bowel function when there was a change in the resident's bowel and bladder continence during the above mentioned period.

Interview with RN #105 revealed that the continence and bowel function assessment is required to be completed on admission and when there is a change in the resident's continence status.

A review of the home's policy #RC-0520-00, titled "Urinary Continence Management", dated April 01, 2016, indicated registered staff to complete Continence Assessment within 10 days of admission. The policy indicated to reassess the resident as required for any change in resident's health status which affect continence.

A review of the home's policy #RC-0520-04, titled "Management of Bowel Function", published April 01, 2016, indicated to complete Bowel Function Assessment tool within seven days of admission and as required by a change in resident's medical condition that affects continence.

Interview with Nurse Manager #115 revealed that he/she could not find any assessment completed for the resident at admission and when there was a change in the resident's continence status. [s. 51. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Observation on November 9, 2017, at 1230 hours on an identified unit revealed two controlled medications (narcotics) in the drawer of the medication cart, in a medication cup. According to the registered nurse staff #110 the narcotics were pre-poured to be ready for administering at 1300 hrs and confirmed that they should be taken out from the original package at the moment of administration. [s. 126.]

WN #6: 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).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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: skin and wound care management.

A review of the home's education record for skin and wound care for 2016 revealed that 80% direct care staff received education and 20 % staff did not receive education in 2016.

Interview with Nurse Manager #115 confirmed the above mentioned statistics and confirmed that 20 % direct care staff did not receive education and are regularly scheduled to work in the home. [s. 221. (1) 2.]

2. The licensee has failed to ensure that 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: continence care and bowel management.

A review of the home's education record for continence care for 2016 revealed that 89% direct care staff received education and 11 % staff did not receive education in 2016.

Interview with Nurse Manager and a lead of Continence Care Program #115 confirmed that the above mentioned statistics and confirmed 11 % direct care staff did not receive education and are regularly scheduled to work in the home. [s. 221. (1) 3.]

Issued on this 30th day of November, 2017

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

Original report signed by the inspector.