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
Feb 5, 2018	2017_547591_0022	028588-17	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Streetville Care Community
1742 BRISTOL ROAD WEST MISSISSAUGA ON L5M 1X9

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

NATASHA JONES (591), KELLY HAYES (583)

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): December 15, 18, 19, 20, and 21, 2017.

During the course of the inspection, the inspector(s) spoke with Interim Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Resident Assessment Instrument (RAI) Coordinator, registered staff, personal care aids (PCAs), Residents and substitute decision makers (SDMs).

During the course of the inspection the inspectors toured the home, observed resident care, conducted staff and resident interviews, reviewed the home's policies, procedures and resident clinical health records.

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

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
3 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In December 2017, resident #019's bed system was observed while the resident was in bed. Two rails were noted to be loose and there was a gap between the mattress and bed rail with a potential zone of entrapment. The top of the bed frame did not have keepers but there were two straps at the top of the mattress that could be fastened to the bed frame. The straps were not fastened and the top of the mattress was not secured to the bed frame.
A review of the plan of care identified that resident #019 required total care from two staff. Both half bed rails were assessed to be used as a Personal Assistance Services Device (PASD). In an interview with the RAI Coordinator it was confirmed that staff used the bed rails for positioning the resident when providing care but that resident did not use the rails as a PASD when staff were not present. The rails were used in the up position when the resident was in bed at all times, including when care wasn’t being provided.
A review of the bed entrapment inspection sheet indicated that resident #019’s bed system failed all zones of entrapment, but did not identify any follow up corrective actions. A review of the “Bed Safety Assessment V5” and the “Restraint/PASD Assessment V2” assessments did not identify any steps taken to prevent resident entrapment. This was confirmed by the RAI coordinator in an interview. [s. 15. (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 that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice, unless contraindicated by a medical indication.

For the purpose of this section, "bathing" includes tub baths, showers, and full body sponge baths.

During the initial tour of the home in December 2017, residents #024, #015, #025, #026 and #027 were observed lined up in a row in the hallway outside the tub room. At the time of the observation no staff were present in the tub room. In an interview with registered staff #116, it was identified the residents were waiting to be bathed, and that there was only one tub room in the home.

The shower rooms were observed during the tour and were noted to be small in size (with the showering chair occupying most of the available space) and there was noted to be a raised edge on the floor at the entrance. During interviews with multiple personal care aides (PCAs) it was shared that most residents in the home received one bath and one shower per week, and those resident who could not safely access the shower room

received a bed bath. Staff shared that the following were some of the limiting factors:
i) The shower chair was large and difficult to position in the small shower room and it was difficult to lift it over the lip on the floor. Therefore the shower chair was usually left in the shower room, and the resident would have to transfer onto the shower chair in the shower room.
ii) Mechanical transfer equipment could not fit in the shower room along with two staff to complete a transfer to the shower chair. Most resident’s wheel chairs along with one or two staff members could not fit in the shower room with enough space to safely transfer the residents.

A) During an interview with resident #019’s substitute decision maker (SDM), they shared that the resident only received one tub bath per week and that it was their preference that the resident received two.

The resident’s written plan of care indicated that they received one tub bath and one shower per week on specified dates. In an interview with the SDM they shared it was their understanding that the home could only provide one bath per week.

In an interview with PCA #111 it was confirmed that on the resident’s shower day they were provided a bed bath. They shared that the home’s shower room was not accessible for resident #019.

B) During an interview with resident #012’s SDM, they shared that the resident only received one tub bath per week and that it was their preference that the resident received two. Resident #012 shared they preferred to have a bath rather than a shower.

The resident’s written plan of care indicated that they received one tub bath and one shower per week on specified dates. In an interview with the SDM they shared the resident was unable to use the shower room as it was not accessible. They shared they were told only one tub bath could be provided.

C) In an interview with resident #018, they shared they received two baths per week but their preference was to have a shower.

The resident’s written plan of care indicated they received two baths per week. In an interview with PCAs #112 and #114 shared the home’s shower room was not accessible for resident #112.

D) Residents #021, #022 and #023 were listed on the shower schedule. PCAs #104, #108, #110 and #113 were interviewed. It was confirmed that all three residents received a bed bath instead of a shower. It was identified that the home's shower room was not accessible for these residents. It was confirmed the resident's received one bed bath per week and one tub bath per week. Inspector #583 asked if it was the resident's preference to receive a bed bath. The staff shared it was common practice in the home that most residents received one tub bath and one shower per week and that for any resident who could not access the shower room, a bed bath was provided.

It was confirmed that not all residents in the home were being bathed at a minimum of twice per week by the method of their choice. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice, unless contraindicated by a medical indication, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

In an interview, the Resident's Council member stated that at times there had been delays in getting a response from the home's leadership to their concerns, and that the Council was not provide with written responses to their concerns or recommendations within ten days.
A review of the Resident Council meeting minutes and related documentation did not include evidence that concerns raised by the Council were responded to in writing within ten days of the concern being brought forward. A review of a document titled "Resident's Council Concern and Recommendation Form", dated October 10, 2017, was signed by the ED, but not by a Council member.
In an interview, the Director of Resident Programs and Admissions confirmed they were the staff representative for the Resident Council. The Director stated concerns raised by the Council were brought to their attention, and they documented the concern on the corresponding form. The form was then forwarded to the department head related to the concern or recommendation for their written response, which was provided within ten days; however, a copy of the written response was not given to the Council and the concern is not discussed until the next scheduled Council meeting.
The home did not ensure a written response to concerns or recommendations was provided to the Resident's Council within ten days of receipt of the concern or recommendation. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #4: 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 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 were documented.

An observation in December 2017, of resident #006’s medication administration record (MAR) during their medication pass, revealed a dose of an identified medication was not documented as having been administered the day before.
In an interview, registered staff #100 confirmed the dose was not signed for on the MAR.
A review of the home’s policy #3-6, titled "The Medication Pass", dated February 2017 stated “document on MAR in proper space for each medication administered or document by code if medication not given”.
In an interview, registered staff #102, confirmed that the medication was not documented as having been administered as ordered. They further confirmed there was no documentation in the resident’s clinical health record to indicate that the medication was refused by the resident.
Registered staff #103 confirmed that they had administered the medication, however; they forgot to document the administration in resident #006’s MAR.
In an interview, the Director of Care (DOC) confirmed the medication administered to resident #006 as mentioned above was not documented. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was dressed in accordance with their preference and in their own clothes.

During an interview with resident #019's SDM, they shared that the resident was dressed inappropriately at times.
During an observation, resident #019 was observed in inappropriate dress. Resident #019's written care plan was reviewed and did not identify any reason why the resident should not be dressed as preferred.
It was confirmed resident #019 was not dressed per the SDM's preference. [s. 40.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

In an interview, the DOC indicated the home's interdisciplinary team met on February 2, 2017, to evaluate the medication management system.
A review of a document titled "Resident Safety Committee Circle of Care - Nursing Practice Committee Minutes", dated Feb 2, 2017, confirmed the meeting; however, a review of the meeting participants did not include the attendance of the registered dietitian (RD).
A review of the home' policy #9-1, titled "Medication Incident Reporting", dated February 2017, indicated "all medication incidents are reviewed by the home 'interdisciplinary team' including the Administrator, the Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist". The RD was not included.
In an interview, the DOC confirmed the RD did not attend the annual evaluation of the medication management system in the February 2017 meeting. [s. 116. (1)]

2. The licensee failed to ensure the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year as referred to in section 115.

In an interview, the DOC indicated the home conducted monthly reviews of medication incidences; however, quarterly evaluations were not conducted.
A review of the home's document titled "Resident Safety Committee Circle of Care - Nursing Practice Committee Minutes", dated Feb 2, 2017, did not include quarterly evaluations.
The DOC confirmed in an interview that the annual evaluation of the medication management system was conducted during the above mentioned meeting, and they further confirmed the evaluation did not include a review of quarterly evaluations in the previous year. [s. 116. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies.

On December 20, 2017, an inspection of the medication cart revealed two resident hearing aid cases were stored in a drawer in the cart.
In an interview on December 20, 2017, registered staff #100 indicated that resident hearing aids were kept in the medication cart for safe-keeping overnight and then applied to the respective resident the following morning. Registered staff #102 indicated that it was the home's practice to obtain a physician's order to store hearing aids of cognitively impaired resident's in the medication cart for safe-keeping while not in use. The Director of Care (DOC) confirmed the above mentioned practice.
The home failed to ensure the medication cart was used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and
(b) reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

An observation on December 20, 2017, of resident #006’s medication administration record (MAR) during their medication pass revealed a dose of an identified medication was not documented as having been administered the day before.
Registered staff #100 and #102 in interviews confirmed that the medication dose in resident #006’s MAR was not documented as having been administered.

Registered staff #103 confirmed they administered the medication to resident #006; however, they did not document in the MAR that they had done so. They did not complete a medication incident form, and the resident's SDM was not notified of the incident.
In an interview, the DOC confirmed the above mentioned medication incident was not documented and further indicated it was not the home's practice to report medication incidences to the resident's SDM unless the resident suffered an adverse effect.
A review of the home's policy #9-1, titled "Medication Incident Reporting", dated February 2017, stated:
a)"'the Medication Incident Report is used to document any incident involving medication or adverse drug reaction regardless of origin",
b)"complete 'Medication Incident Report' online when a medication incident or adverse drug reaction has occurred", and
c) "every medication incident and adverse drug reaction involving a resident directly will require a designate from the home to notify the resident or the resident's substitute decision maker that an incident has reached the resident", and,
d)"every medication incident or adverse drug reaction involving a resident is to be reported to the resident or the resident's substitute decision-maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/Clinical Consultant Pharmacist".
The home failed to ensure the above mentioned medication incident involving resident #006 was documented and that their SDM was notified of the incident. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In an interview, the DOC indicated the home conducted monthly reviews of medication incidences, reviewing incidences that occurred in he month prior to the meeting; however, quarterly reviews were not conducted.
A review of the home's policy #9-1, titled "Medication Incident Reporting", dated February 2017, stated "the medication incident report is reviewed, analyzed and included in the evaluation at the home in order to reduce and prevent medication incidents and adverse drug reactions". The policy did not include the frequency for the reviews.
The home failed to ensure medication incidences and adverse drug reactions were reviewed quarterly. [s. 135. (3)]

Issued on this 7th day of February, 2018

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

Original report signed by the inspector.