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
Dec 13, 2016	2016_546585_0017	033407-16	Resident Quality Inspection

Licensee/Titulaire de permis

CLARION NURSING HOMES LIMITED
337 HIGHWAY #8 STONEY CREEK ON L8G 1E7

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

CLARION NURSING HOME
337 HIGHWAY #8 STONEY CREEK ON L8G 1E7

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

LEAH CURLE (585), LESLEY EDWARDS (506)

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): November 30, December 1, 2, 6, 7, 2016.

Concurrent to the Resident Quality Inspection (RQI), Critical Incident (CI) 2721-000004-16/log# 023420-16 regarding alleged staff-to-resident abuse was inspected.

During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, personal support workers (PSWs), the Environmental Services Manager (ESM), Maintenance Supervisor, Activities Director, Dietary Supervisor, Registered Dietitian (RD), Relief Director of Care (RDOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed care and services provided to residents, reviewed documents and records which included, but was not limited to: resident clinical health records, dietary notes, policies, logs, investigation records, staff records, meeting minutes and program evaluations.

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
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

9 WN(s)
7 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the long term care home was a safe and secure environment for its residents.

During a medication pass observation on a specified date in December 2016, after administering medication to a resident using a needle, registered staff #106 placed the used needle in a small yellow sharps container which did not have a lid. The container had several other used needles and sharps in it and was located on the outside of the medication cart with the clean cups, which were accessible to residents. Registered staff #106 confirmed they were not using an appropriate sharps container and they were not ensuring a safe environment for residents. [s. 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 and ensuring that the home is a safe and secure environment for its residents, 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 failed to ensure that there was a written plan of care that set out the planned care for the resident.

Review of resident #033's progress notes revealed documentation by the Registered Dietitian (RD) in November 2015, that stated staff were to use a specified feeding device; however, the written plan of care did not reflect direction any technique or approach for safe feeding. The RD reported staff were to be seated and use a specified feeding device when providing food and fluids to the resident, and confirmed the written plan of care did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #011's plan of care identified they were at nutrition risk related to a diagnosis. Information to direct staff regarding the resident's dietary requirements and interventions, known as the written plan of care, were located in: the care plan, intended for registered staff; kardex, intended for PSWs, and dietary serving notes, intended for dietary staff. Review of the resident's care plan and kardex stated they were to avoid consuming specified foods. Review of the dietary serving notes did not state the resident was to avoid the specified foods. The RD confirmed the written plan of care did not provide clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (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 and ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, 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 failed to ensure that the home and equipment were kept clean and sanitary.

On November 30, 2016, during a tour of the home, the bath tub in the spa room on the lower level was observed unclean and unsanitary. The tub was observed to have a layer of debris, with crunched up soiled paper towel, briefs and towels in the interior of the tub. Interview with registered staff #102 reported the tub was not in use at the time of the observation; however, confirmed the home's expectation was that the tub be kept clean and sanitary at all times and ready for resident use. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to the behaviours, where possible.

On an identified date in July 2016, the home submitted a Critical Incident System (CIS) report regarding alleged staff to resident abuse. The CIS report and investigation records stated that on the same day, PSW #113 and staff #112 observed PSW #114 abuse resident #030. The records revealed that the resident did not acquire an injury and allegations of abuse were unfounded.

In interviews with Long-Term Care (LTC) Homes inspector#585, staff #112 and PSW #113 reported they observed PSW #114 attempt to provide resident #030 assistance with their daily living; however, the resident was demonstrating responsive behaviours. PSW #114 confirmed they provided care to resident #030, the resident was exhibiting responsive behaviours; however, they continued to provide assistance to the resident.

Review of resident #030's plan of care stated they had a specified diagnosis and an intervention, effective in June 2016, to be implemented by staff when the resident demonstrated a specified responsive behaviour. On an identified date in July 2016, PSW #114 failed to ensure that strategies were implemented to respond to resident #030's responsive behaviour. [s. 53. (4) (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 and ensuring that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #5: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date in December 2016, PSW #110 was observed using improper techniques to assist resident #033 with eating. PSW #110 reported it was their practice use the observed techniques when they provided assistance to the resident. Interview with the RD confirmed PSW #110 should have been using proper techniques and a specified feeding device when assisting the resident. [s. 73. (1) 10.]

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 and ensuring that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

The licensee failed to ensure that the following requirements were 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.

On an identified date and time in November 2016, resident #031 was observed with a physical device applied with a space of approximately five inches between the resident and the device. Review of the resident's plan of care revealed they used the device for safety.

Interview with registered staff #102 confirmed the device appeared loose; however, was unaware of the appropriate application of the device. Interview with the DOC who reported the expectation would be that staff apply the belt with a space no more than two finger widths between the resident and the device. [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 and ensuring 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that where drugs were stored, access to those areas were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On December 2, 2016, registered staff #101 was reviewing the process in the home for medication destruction with LTC Homes inspector #506. Registered staff #101 took inspector #506 to the second floor boiler room which was locked. Once in the boiler room, registered staff #101 proceeded to open a door that had a sliding latch that could be opened by anyone, where boxes of medications were located, waiting to be denatured. Interview with the maintenance supervisor confirmed they had a key to the boiler room and had access to the area containing the medications. The licensee failed to ensure where drugs were stored, the area was restricted to only persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 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 and ensuring that steps are taken to ensure the security of the drug supply, access to areas where drugs are stored areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours.

The home's policy, "Quality Management, Urine Odour Audit, Index I.D ES C-25-15", revised January 21, 2015, stated, "when a concern of lingering urine odour is identified the Urine Odour Audit form must be completed by the ESM. This will include the conclusion and suggested action to eliminate the odours".

On November 30, 2016, a strong offensive odour was noted in the shared washroom located in room #207. On December 2, 2016, the offensive odour remained, despite recent cleaning by housekeeper #107. Interview with PSW #108 and PSW #109 reported the shared washroom in room #207 always had a strong odour.

Interview with housekeeping staff #107, who was a regular staff member, confirmed the shared washroom in room #207, room #212, room #219 and room #224 had persistent odours despite daily cleaning. Housekeeping staff #107 reported there was no process in the home for addressing incidents of offensive odours.

Interview with the Environmental Services Manager (ESM) reported the home's process for managing offensive odours in washrooms was for staff to verbally report concerns to the ESM and a deep clean would be performed. The ESM reported they were recently made aware of an offensive odour in the shared washroom in room #212; however, was unaware of the odours in the other shared washrooms. [s. 87. (2) (d)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

Ontario Regulation (O. Reg.) 79/10, r. 99. (b) and (d) outline that: (b) at least once in every calendar year, the licensee is required to ensure that an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences; and (d) that the changes and improvements under clause (b) are promptly implemented.

Review of the home's annual evaluation for their abuse policy did not include a written record of everything provided for in clauses (b) and (d); and the date that the changes and improvements were implemented. Interview with the DOC reported that the home's abuse policy and program were evaluated annually; however, confirmed that their documentation did not support a clear written record of the evaluation. [s. 99. (e)]

Issued on this 5th day of January, 2017

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

Original report signed by the inspector.