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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 17, 2014	2014_240506_0025	T-000017-14	Resident Quality Inspection

Licensee/Titulaire de permis

COLLINGWOOD NURSING HOME LIMITED
250 CAMPBELL STREET, COLLINGWOOD, ON, L9Y-4J9

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

COLLINGWOOD NURSING HOME
250 CAMPBELL STREET, COLLINGWOOD, ON, L9Y-4J9

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

LESLEY EDWARDS (506), CATHIE ROBITAILLE (536), JESSICA PALADINO (586)

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 4,5,6,7,12,13 and 14, 2014

This inspection was conducted concurrently with Complaint Inspections T-283-13, T-335-13, T-1109-14, T-771-14 and T-1181-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, personal support workers (PSW), dietary staff, Registered Dietitian (RD), Activity Director, Dietary Manager, Maintenance Manager, Owner of Superior Facilities Services, Convalescent Care Unit Manager, housekeeping staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed residents,reviewed resident health records, meeting minutes, policies and procedures, schedules, education records and complaint logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
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. (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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for resident #005 that set out the planned care for the resident related to bed rail use.

Resident #005 used bed rails in the raised position at all times when in bed as

confirmed by observation and staff interviews on an identified date in November, 2014. Staff interviewed were aware of the use of the rails which was an assessed need. The written plan of care and kardex, which provided direction to front line staff, did not include the use of the bed rails, which was confirmed during an interview with the registered staff. [s. 6. (1) (a)]

2. The licensee did not ensure that staff and others involved in different aspects of care of the resident collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

Resident #204 had a physician's order to remove an intervention from an area on the resident on an identified date in July 2014. The registered staff began to remove the intervention and after reassessment of the intervention, decided to leave it in place and a progress note was completed.

i. The physician was not notified that the intervention was left in place and requested to reassess the area.
ii. There was no documentation in the day planner to alert staff for reassessment or removal of the remaining intervention.
iii. It was not documented in the resident electronic treatment assessment record when to remove the intervention or that the intervention was still in place.
iv. There was no documentation of the area or the intervention.
v. During daily assessment it was documented that the area was healed and there was no mention of the intervention still being in place.
vi. On an identified date in August 2014, the resident was transferred to another long term care facility. There was no mention in the transfer records to the receiving long term care home that the resident still had the intervention in place and when the intervention was to be removed.
vii. The home was not aware that the intervention were still in place until the DOC from the receiving facility called the home to inquire about the intervention that were still in place for this resident.
The ADOC confirmed that the assessments were not consistent and did not complement each other. [s. 6. (4) (a)]

3. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated

and are consistent with and complement each other.

Resident #100 experienced multiple falls between September - October, 2012. During an assessment by the Occupational Therapist (OT) on an identified date in October, 2012, the OT suggested the resident may benefit from an intervention as they had experienced recent falls. The OT documented this recommendation again on an identified date in November 2012. Review of the resident's health record and interview with the ADOC on an identified date in November, 2014 confirmed that a follow-up was never completed and the resident was not given the intervention. The resident experienced multiple falls since that time, including a fall on an identified date in June, 2013 that resulted in an injury. There had not been any further implementation, development or follow-up regarding the use of the intervention to mitigate the resident's fall risk. [s. 6. (4) (b)]

4. The licensee did not ensure that any other person designated by the resident or substitute decision maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #204 suffered an injury following a fall on an identified date in June, 2014. On return from hospital, a family member advised the home that resident #204 had a specific strategy while in the hospital, and requested that the resident have a specific strategy while in bed to prevent further falls. The family member was advised that the home was a restraint-free home. Education on risks associated with the specific strategy was provided to the family member. Interventions were put into place by the home; however, the family continued to request the use of the specific strategy to no avail. The ADOC confirmed that residents have the right to participate in the development of the plan of care. [s. 6. (5)]

5. The licensee did not ensure that the care set out in the plan of care was provided to resident #203 as specified in their plan.

A) During a review of resident #203's clinical record it was noted that the resident was not given breakthrough medications when the resident's personal pain goal exceeded four out of ten on the pain scale.

i. In May 2014, the resident was not given their identified strategy two times when their pain goal exceeded four on the pain scale.
ii. In June 2014, the resident was not given their identified strategy five times when

their pain goal exceeded four on the pain scale.
iii. In July 2014, the resident was not given their identified strategy six times when their pain goal exceeded four on the pain scale.
The DOC confirmed that the staff were not administering resident #203's identified strategy as specified in the resident's plan of care.

B) Resident #006 experienced a significant weight loss from August to November, 2014.

i. Review of the resident's health record revealed that the resident's intake declined because they were refusing to eat their meals.

ii. Interview with the RD on November 12, 2014 and review of the resident's documented care plan revealed that staff were to use a specific strategy to encourage eating. A progress note by the RD on an identified date in October, 2014 confirmed that this intervention appeared to be successful in improving the resident's intake.
iii. Observation of lunch meal service on an identified date in November, 2014 revealed that the resident was served their entrée not using the specific strategy. The resident was observed inspecting their food with their utensils and then did not eat any of it. When offered dessert the specific strategy was not used, the resident refused stating that they did not want any because it had been tampered with. (586) [s. 6. (7)]

6. The licensee did not ensure that resident #003's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) On identified dates in November 2014, resident #003's bed was observed to have two one-quarter bed rails up. Interview with the registered staff confirmed the resident used two one-quarter rails while in bed for safety. Review of the resident's documented plan of care indicated that the bed rails were to be left down to prevent the resident from climbing over them. The resident's plan of care was not revised and updated when their care needs changed.

B) On identified dates in November 2014, resident #003 was observed in their wheelchair without a seat belt. Review of the resident's progress notes from an identified date in August, 2014 confirmed that the resident's use of a seat belt as a restraint was discontinued, however the documented plan of care indicated that staff are to ensure the resident is wearing a seat belt while in their wheelchair, Interview

with the registered staff confirmed the resident no longer required a seat belt. The resident's plan of care was not revised when their care needs changed. [s. 6. (10) (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 there is a written plan of care for each resident that sets out the planned care; to ensure that staff and others collaborate with each other; to ensure that substitute decision makers have the opportunity to participate in the plan of care; to ensure the care set out in each resident's plan of care is provided to the residents as specified in their plans; and to ensure each resident's plan of care is reviewed and revised when their care needs change, to be implemented voluntarily.

WN #2: 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 did not ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the inspection on an identified date in November, 2014 it was observed that various beds had loose full rails in place in residents' rooms. Residents were not in these beds at the time of observation; however, staff confirmed that the residents used these rails for positioning and transferring. The rails were unstable and very wobbly and in one room the rail was not attached to the bed. The side rails were not safe for resident transfers and the loose rails may also contribute to entrapment zone risks. [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 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in July, 2013, resident #204 returned from the hospital with an injury and the resident had specific areas requiring assessment and treatment. Staff interviewed and documentation confirmed that the resident's skin was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee did not ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #203 was noted to have impaired skin on several areas of their body and some areas were noted to be open. These areas of altered skin integrity were noted on an identified date in April, 2014. Wound assessments were not consistently completed weekly after that:

i) in April, completed 1 of an expected 3 assessments;
ii) in May, completed 1 of an expected 4 assessments;
iii) in June completed 1 of an expected 5 assessments;
iv) in July, completed 1 of an expected 4 assessments;
v) in August, completed 3 of 4 assessments;
vi) in September, completed 3 out of 4 assessments;
vii) in October, completed 4 of an expected 5.
The Director of care confirmed that the weekly wound assessments were not completed weekly.

B) On an identified date in July, 2014, resident #204 returned from the hospital with an injury and the resident had a specific area requiring assessment and treatment. Wound assessments were not consistently completed weekly:

i. In July, completed 1 of an expected 4 assessments;
ii. In August, completed 0 of an expected 1 assessment.

The ADOC confirmed that the weekly wound assessments were not completed weekly. [s. 50. (2) (b) (iv)]

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 residents with altered skin integrity receive an assessment using a clinically appropriate tool and receive weekly wound assessments, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's nutrition care and hydration programs included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Review of the home's nutrition and hydration policies and procedures demonstrated that, except for wound care, there was no policy directing staff on when to make referrals to the RD. This was confirmed by the ADOC and RD.
i. Interview with the home's ADOC and RD confirmed that referrals were to be made by registered staff electronically using a Point Click Care (PCC) assessment form titled "Nursing Dietary Referral (RD/FSS) V3". There is no policy directing staff to complete this form when making a referral to the RD.
ii. When the ADOC, RD, and registered staff were interviewed on an identified date in November, 2014, all were unable to confirm when referrals were to be made to the RD regarding poor oral intake and poor fluid intake. Registered staff stated referrals were made based on clinical judgement or changes in resident habits, however confirmed that they had never been given specific direction regarding when to make dietary referrals.
iii. Resident #006's food and fluid records demonstrated that from identified dates in November 2014, the resident consumed 50-75% of meals, the resident consumed 0-25% of all of their meals. From an identified date in October, 2014, the resident only consumed 50-100% of their meal at six out of 49 meals; the remaining were below 50%. The resident had experienced a significant weight loss from August, to November, 2014. Review of the resident's health records revealed a referral was not made to the RD and interview with the RD on an identified date in November, 2014 confirmed that a referral should have been made. [s. 68. (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 to ensure the home's nutrition care and hydration program includes the development and implementation of policies and procedures related to registered dietitian referrals, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance for the building interior which included but is not limited to furnishings, flooring, ceilings, floors, lights, walls and fixtures.

During inspection the following was observed:

i. The linoleum floor in the front foyer had a number of areas ranging in size from: small (one inch) to larger (five to six inches) that linoleum has worn away down to the mesh backing.
ii. Rooms with wall damage and heavily scraped and/or gouged areas in rooms: #2, #3, #4, #6, #7 , #10, #12, #16, #17, #18, #20 and #23.
iii. Broken floor tiles in room #20.
iv. Radiators rusty and heavily scratched in room #17.
v. Radiators in dining room attached however; pulled away from the wall, and the radiator across from Activity office had the face plate fall off when touched.
vi. Splintered or chipped doors in resident rooms: #4, #10, #12, #14 and #16.
vii. Most metal door frames in building were heavily scratched.
viii. Bathroom floor edges lifting in room #14.
ix. Caulking around base of toilets, black or rust coloured in rooms: #5, #10, #11 and #20.
x. Dining room chairs and lounge chairs had badly scratched wooden legs.

A walkthrough was done of the home with the Administrator on an identified date in November, 2014. The Administrator confirmed that the home had no current written process in place to address preventative or remedial maintenance of the identified areas of concern noted. [s. 90. (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 there are schedules and procedures in place for routine, preventive and remedial maintenance for the building interior which included but is not limited to furnishings, fixtures and flooring, 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure every resident has the right to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On an identified date in June, 2013, resident #100's substitute decision-maker (SDM) submitted a written request to the home's Administrator for copies of certain documents from the resident's health record. Interview with the resident's SDM on an identified date in November, 2014 revealed these documents were not provided to the resident's SDM. On an identified date in November, 2014, the Administrator was unable to confirm that these items from the resident's documented plan of care were provided to the SDM as per their request. [s. 3. (1) 11. iv.]

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 did not ensure that the policy and procedure for pain assessments was complied with.

A) The home's Resident Service Manual policy for pain assessments (section 4.14.0, subsection 4.14.1 page 9 last revised June 2014) indicated that the interdisciplinary team shall conduct and document a pain assessment: when a resident states that pain severity is a four out of ten or greater.

During a review of resident #203's clinical record it was noted that the resident was to receive pain assessments when the resident's pain was documented a four or more on their pain tracking tool.
i. On the June 2014 pain tracking tool there were 17 days where the resident stated their pain was greater than four and a pain assessment was not conducted.
ii. On the July 2014 pain tracking tool there were eight days where the resident stated their pain was greater than four and a pain assessment was not completed. The DOC confirmed that the staff were not completing pain assessments as per the home's policy.

B) The home's Resident Service Manual policy for pain assessments (section 4.14.0, subsection 4.14.1 page 9 last revised June 2014) indicated that the interdisciplinary team shall conduct and document a pain assessment: when the resident is receiving breakthrough pain related medication for greater than 72 hours.

During a review of resident #203's clinical record it was noted that the resident was to receive pain assessments when the resident was given breakthrough pain medication for greater than 72 hours.
i. In June 2014, resident #203 was given breakthrough pain medication from June 1-5, June 10-15, and June 18-22, 2014, and a pain assessment was not completed.
ii. In July 2014, resident # 203 was given breakthrough pain medication from July 1-4 and July 24-28, 2014 and a pain assessment was not completed. The DOC confirmed that the staff were not completing pain assessments as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented for proper cleaning of floors.

During inspection the following was observed:

i. Bathroom floors with heavily blackened areas in rooms #3, 5, 7, 11, 14, 16, 17, 18, 19, 20, 22, 26 and 28.
ii. Bedroom floors with heavily blackened areas in rooms #5, #6, #7, #8, 9, 11, 12, 14, 15, 16, 19, 20, 21, 22, 23 and 28.
iii. Hall floors with heavily blackened areas
iv. Dining room floors with heavily blackened areas

The licensee's policy "Housekeeping procedures" (reviewed/revised 03/13), referred to floor care and maintenance procedures. The staff were following the procedures; however, the procedures were ineffective in removing the blackened areas. A walk through of the home was done with the Administrator on an identified date in November, 2014. The Administrator confirmed the poor status of the floors. [s. 87. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Resident #100 experienced a fall on an identified date in June, 2013 resulting in a transfer to hospital with an injury. The resident returned to the home that day on bed rest, then was re-admitted to the hospital on an identified date in June, 2013 with complications.

i. An incident report was submitted to the Director on an identified date in June, 2013; greater than one business day after the incident occurred.
ii. A request for amendment was made to the home asking for more information regarding what interventions were in place prior to the fall, as well as the residents ambulation and transfer ability; however record review and interview with the Administrator and ADOC on an identified date in November, 2014 confirmed that this amendment was not completed. [s. 107. (3)]

WN #10: 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 :

1. The licensee did not ensure that residents # 200 and #201 seat belts were applied according to manufacturer's guidelines.

On an identified date in November, 2014, residents #200 and #201 were noted to be wearing seat belts that were loose fitting and not applied according to manufacturer's guidelines. Interview with the DOC on an identified date in November, 2014, confirmed that the seat belts were restraints and that both residents could not remove the seat belts. Staff was aware, based on education that they had received, that seat belts used to restrain a resident should be tightened to the distance of approximately two finger widths. The seat belts observed on an identified date in November, 2014 were more than five inches from the residents' thighs which was not in accordance with the manufacturer's guidelines. [s. 110. (1) 1.]

WN #11: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection control program.

On an identified date in November, 2014 during the walk through of the tub room it was noted there were open, used unlabelled jars of zinc oxide, vita-rub, body butter and Vaseline in the cupboard. One unlabelled jar of zinc oxide was also noted in the linen room in the care caddies that the staff use for resident care. The ADOC confirmed that all open jars of creams should be labelled. [s. 229. (4)]

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 27th day of November, 2014

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

Lesley Edwards