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

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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
Oct 24, 2014	2014_360111_0025	000624, 000221	Complaint

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 1-3, 2014

2 complaint inspections (log# 000221 & 000629) were completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the resident, a family member, Physiotherapy Assistant (PTA),Restorative Care Aide (RCA), Registered Nurse(RN), Registered Practical Nurses(RPN), and Personal Support Workers(PSW).

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to ensure the written plan of care for Resident #1 was provided related to positioning.

Observation of Resident#1 on a specified date indicated the resident was in bed, and the resident's head was improperly positioned. A small positioning pillow was located on the floor to the right side of the bed. The resident rang the call bell at the inspectors direction and a PSW entered the room, turned off the call bell and proceeded to pick up the pillow that was on the floor and placed the pillow on the residents bed). The PSW repositioned the resident after prompted by the inspector that the resident was improperly positioned and the positioning pillow was not used.

Interview of Resident #1 indicated the resident required pillows for repositioning while in bed and when up in wheelchair due to lack of trunk support.

Review of the care plan (current) for Resident #1 indicated under bed mobility, the resident requires full staff assistance with positioning related to diagnoses. The interventions included:staff to turn and reposition every two hours, and use pillows to aid in positioning and comfort. [s. 6. (7)]

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 written plan of care is provided to residents related to positioning, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was accessible for Resident#1 use at all times.

Observation of Resident#1 on a specified date for a 4 hour period indicated the call bell was placed in the residents' lap towards the right side, inaccessible to the resident due to weakness. Interview of Resident #1 indicated sometimes they have "to wait a long time for staff to respond to calls". When the call bell was provided to the resident and the resident activated the call bell, a PSW responded in a timely manner. The PSW then clipped the call bell to the residents' right upper thigh area of pants (where the resident could not reach).

Observation and interview of Resident #1 on the following day indicated the resident was up in a mobility aide. The call bell was left on the resident's bed (not accessible to the resident). Interview of a family member (who was visiting the resident at the time) indicated upon arrival, the resident's call bell was not within the residents' reach. [s. 17. (1) (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 resident-staff communication and response system is accessible to all residents at all times, to be implemented voluntarily.

WN #3: 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Review of the current care plan for Resident #1 indicated the resident is diagnosed with an infectious condition requiring the use of contact precautions to notify visitors and staff of resident's precautions (including staff to wear gown and gloves when providing care and staff to perform hand hygiene after contact with resident, and staff to designate a sling and commode for use).

Interview of the DOC indicated that Resident #1 has a sling that is kept on the back of resident door and a commode designated for use due to diagnosis and is normally stored in the shower room.

Observation of Resident#1 room on a specified date for a 4 hour period indicated there was personal protective equipment (PPE's) (yellow gowns and gloves) available and a contact precautions signage posted directing staff which PPE's to use when performing personal care. The resident's bathroom had an unlabelled denture cup on the counter and this is a shared bathroom. Observation of Resident #1 on the following day indicated there was PPE's available and a contact precautions signage on the door. The resident was up in a mobility aide after being toileted with assistance of two PSW's. One PSW remained in the room to clean the soiled commode. The PSW was observed only wearing gloves and no gown. The PSW then asked the visiting family member to push down on the commode seat seat without the use of any PPE's. The PSW then proceeded to clean the soiled commode in the resident's washroom without wearing a gown as directed on the contact precautions. The commode was left in the shared washroom and was not labelled as designated for use only for Resident#1. Interview of the visiting family member indicated neither of the 2 PSW's were wearing a yellow gown while performing toileting of the resident.[s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

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Issued on this 28th day of November, 2014

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

Original report signed by the inspector.