Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2014	2014_285546_0019	O-000509-14	Resident Quality Inspection

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 (ALEXANDRIA)
92 CENTRE STREET, ALEXANDRIA, ON, K0C-1A0

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

SUSAN WENDT (546), JOANNE HENRIE (550), LISA KLUKE (547)

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): June 10, 11, 12, 13, 16, 17, 18, 19 and 20, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Administrative Assistant, the Environmental Manager, several Housekeeping aides, one Handyperson, the Food Services Supervisor, the Activity Director, several activity aides, the RAI Coordinator, the Back-up RAI Coordinator, the Registered Dietitian, the Pharmacist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), one Dietary Aide, one Laundry Aide, one OT/PT Assistant, President of the Residents' Council, several members of the Family Council, several family members and several residents.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, resident care, meal services, medication administration, reviewed several residents’ health care records, including plans of care, medication and treatment records and PSW care flow sheets. Several home policies were reviewed including policies related to the Falls Prevention Program, the infection control program related to both, residents and staff, the medication administration and disposal management system and the Preventative Maintenance Program. In addition, Residents' Council minutes and Family Council minutes were reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

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. 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 :

The licensee has failed to comply with LTCHA, S.O. 2007, c.8, s. 15. (2) (a) in that the

home, furnishings and equipment were not clean and sanitary.

During the RQI inspection, the team of LTCH inspectors observed the following regarding the housekeeping areas on the second floor:

On a specific day in June 2014, Inspector #547 observed in the “Salle des Residents” dining area that the baseboard to the servery wall had a corner with a two inch gap where sticky dark matter was embedded with food and dust debris on the floor that came away with Inspector #547's nail. The wooden counter top at the servery (where all resident meals are handed to staff) had several indentations into the wood, where the sealant has been removed exposing the porous material whereby crevices had stuck on food debris and dried fluid markings which made the counter top surface very sticky to touch. The laminate covered wall beneath this counter top had streaks of dried fluid down the wall to the baseboards. It was also noted that the windowed wall to the left of the dining room doorway had dried food debris on both lower window and the metal frame for this wall. Residents were observed seated next to this wall for meals.

On a specific day in June 2014, Inspector #547 observed that a resident’s room that had several areas where the baseboards were broken or separated from the wall where dark dried matter was embedded into these crevices and edge of the floor and baseboard. Significant damage was noted next to the toilet, whereby the baseboard has had water damage, and separated from the wall with significant amount of dust, debris as well as soiled toilet paper stuck in this crevice.

Inspector #547 also observed this room to have a soiled privacy curtain between both residents’ beds.

During the RQI inspection, the team observed the following regarding the housekeeping areas on the third floor:

On a specific day in June 2014, Inspector #550 noted a resident room's wooden window ledge to have an accumulation of dark brown matter.

On a specific day in June 2014, Inspector #547 noted several resident rooms to have soiled privacy curtains located between the beds of residents who shared these rooms.

On a specific day in June 2014, Inspector #547 noted a resident room to have several areas on the flooring and baseboards with dark matter that came away with Inspector #547's nail.

On a specific day in June 2014, Inspector #547 noted a resident shared washroom had unglued baseboards in several areas around the base of the walls where dust and debris was stuck behind the plastic baseboard panel. The room's flooring had dust and debris stuck to the perimeter of the floor and washroom that came away with Inspector #547's nail.

On a specific day in June 2014, Inspector #550 noted in "Salle des Residents/Residents' Lounge" dining area that all windows with wooden ledges were cracked and covered with duct tape and visibly dirty with food debris and dead flies. The baseboard heaters located under each window were soiled with dust and dried food debris. The linoleum flooring was no longer sealed near the baseboards; dark matter was embedded in several areas of the flooring.

On a specific day in June 2014, Inspector #547, accompanied by the Environmental Manager, observed the flooring of the common Rehabilitation room on the main floor to be stained near the staff desk and dust and debris stuck to the flooring at the base of the baseboards to the perimeter of the room. The Environmental Manager indicated the floor was not cleaned to the Home's expectations, as the baseboards are to be cleaned along with the flooring in every resident care area daily. The Environmental Manager indicated to have reviewed cleaning expectations with housekeeping attendants at their last housekeeping meeting held in March 2014. A review of the last housekeeping audit performed by the Environmental Manager in May 2014 indicated no housekeeping areas to follow-up.

2. The licensee failed to comply with LTCHA, S.O. 2007, c.8, s. 15. (2) (c) in that the home, furnishings and equipment were not maintained in a safe condition and in a good state of repair.

During the RQI inspection, the team of LTCH inspectors made the following observations which presented an indication of widespread failure of the maintenance program, some of which may constitute as potential risk related to resident safety.

Second floor regarding walls and doors:
On a specific day in June 2014, Inspector #547 observed the "Salle des Residents"

dining area on the second floor. Several indentations were noted on the drywall on all 3 walls throughout the room whereby the paint was chipped and the drywall was damaged. The metal frame for the windowed doorway presented with several areas of chipped paint. This dining area had a chair rail particle board which was not affixed to the wall in an area under the air conditioner; sharp edges could be pulled two inches away from the wall exposing dried glue, dust and debris. Two other areas of damaged particle board were identified next to the servery's half-door where the particle board was damaged creating crevices for dirt and debris to gather. The wooden corner trim to the servery bar top had a broken area approximately two feet from the floor exposing a sharp porous wooden edge which had not been maintained, posing risk for residents in this shared dining area.

On a specific day in June 2014, Inspector #547 observed a room having wooden baseboards that were no longer affixed to the wall, where the paint had chipped exposing the porous wood beneath with debris stuck in the crevices of the base of the floor. This same room had corners near the residents' shared closets with missing drywall and plaster exposing the metal corner framing, exposing sharp metal edges posing a risk for the residents in this room.

On a specific day in June 2014, Inspector #546 observed a room having a large hole in the drywall under the right side of the sink in this shared wash room.

On a specific day in June 2014, Inspector #547 observed the following:
- a resident room (a two-bed room) had several areas where the baseboard were broken, or separated from the wall. There was significant damage next to the toilet; the baseboard had previous water damage, separated from the wall with significant amount of dust, debris as well as toilet paper stuck in this area thereby preventing it from being maintained or sanitized. The baseboard near the residents' shared closet was also broken,exposing the metal framing with sharp edges preventing the surface to be cleaned where dust and debris gathered behind these areas. Baseboards were scratched and gouged into the porous wood behind it where the washable surface had been removed.

- a resident room had several areas where the paint had chipped from the wall exposing the drywall beneath, providing a porous surface that could not be cleaned, sanitized or maintained in good state of repair. The door frame to the shared washroom had paint that chipped through two layers of paint on both sides of the doorframe, exposing the metal base of the door, thereby not allowing for a sealed

cleanable surface.

- a resident room (a two-bed room) had a shared washroom with another room which had broken wall tiles with sharp edges by the toilet paper dispenser; this surface was not maintained in a good or safe state of repair.

On a specific day in June 2014, Inspector #547 observed a vacant room to have a bedside table where the second drawer had a four inch by four inch area of rust-like matter to the base.

On a specific day in June 2014, a resident reported to Inspector #547 as having sustained a cut to the left hand after being toileted in the shared bathing room on the toilet next to the tub; the resident indicated that the sharp edges on the dry wall, resulting from the missing toilet paper dispenser were the cause for the cut.
A staff noted this area to be sharp and would report this in PM works for repair.

Second floor regarding baseboard heaters:

On a specific day in June 2014, Inspector #547 observed a severely damaged baseboard heater in the resident care area hallway on the second floor (near the laundry chute); the heater had paint scraped, bent metal areas from impacts, as well as several sharp edges exposed and bent outward at both end plates to this heater box posing a significant risk to residents and staff who regularly use this area to get to and from their rooms to other common areas of the home.

On a specific day in June 2014, Inspector #547 noted a resident room to have metal baseboards heaters beneath each window; the heaters had areas of chipped paint exposing the metal base where rust had developed.

On a specific day in June 2014, Inspector #547 noted that in the resident lounge-living room area on 2nd floor, a baseboard heater was in disrepair where the end plates and mid covering plates were bent outward, posing a risk to residents; this heater had not been maintained in a good or safe state of repair in this shared common area.
Inspector #547, in the company of the DOC, observed these heaters; the DOC was not aware of their need for repair and that they did pose a significant risk to residents, visitors and staff in this common area where many activities were held.

Second floor regarding windows:

On a specific day in June 2014, Inspector #547 noted in a resident room that both wooden window ledges had paint chipped in several areas and crevices; these window ledges had not been properly maintained to provide a sealed cleanable surface.

Second floor regarding furniture:

The resident sitting area, near the elevator, has a hole in the upholstery on the right seat cushion; this seating area, used by residents and visitors, had not been maintained in a good state of repair.

Third floor regarding walls and doors:

On a specific day in June 2014, Inspector #550 observed the following:

-The bathing room (adjacent to the nursing station) had linoleum baseboards there were unglued, thereby exposing plaster near the doorway to the shower and tub areas; the corners of the walls were severally damaged, thereby exposing sharp metal framing, posing a significant risk to residents. The drywall next to the toilet near the tub was damaged with a hole into the drywall. Several indentations were observed in the drywall on the walls throughout the bathing room; the damaged unpainted drywall provided a non-sealed porous area in this humid environment, which could pose a health risk to residents. The privacy curtain in the toilet area of this bathing room was found to be in disrepair with a large hole preventing appropriate privacy.

- a resident room's washroom door was observed to be damaged, thereby exposing porous material.

- a resident room's closet doors were observed to be unattached to the floor track, thereby having the doors rubbing against the floor whenever either door was moved, making it difficult to open or close. Also observed, was the corner of the wall inside the closet which was damaged, thereby exposing porous material.

- a resident room's closet door was observed to be unattached to the floor track, thereby not hanging correctly and causing a hazard. Also observed, was the corner wall near this closet which was damaged, thereby exposing a sharp metal corner frame.

- a resident room's shared washroom had tiles missing on the wall adjacent to the counter sink, thereby exposing dried glue and porous drywall beneath. This same washroom has broken ceramic tiles behind the toilet paper dispenser, exposing several sharp edges, thereby posing a risk to residents who use this shared washroom.

On a specific day in June 2014, Inspector #547 noted the following observations:

- a resident room had wooden baseboards where the chipped paint was exposing several areas of porous material, as well as exposing the sharp edges of the metal corner frame near the residents' shared closet. Above the area, was an improperly affixed corner shield, exposing a sharp metal strapping posing a risk to the residents in this shared room. Also observed, was the chipped paint and the damaged drywall at the head of the resident's bed.

- a resident room was observed to have missing baseboards near the residents' shared closet, exposing dried glue on the drywall. Many areas throughout the room had baseboards bubbled out from the wall where flooring tiles were missing and dust and debris were stuck to the sub floor.

- a resident room's shared washroom was observed to have damaged baseboards and areas no longer affixed to the ceramic tiles, thereby creating crevices where dust and debris had accumulated.

On a specific day in June 2014, Inspector #550 observed the ceiling in the third floor "Salle des Residents/Residents' Lounge" dining area to have two areas of water dripping from the ceiling with pails for water collection beneath them; these were located next to residents' wheelchairs.

On a specific day in June 2014, Inspector #547 observed an improperly attached faucet in a shared washroom; the faucet taps moved freely away from the sink when opening and closing the taps.

Third floor baseboard heater at the end of the resident care area hallway:

On a specific day in June 2014, Inspector #547 observed the baseboard heater cover

to have paint scratched and chipped; the bent metal base beneath it was found to be improperly attached to the heater, whereby Inspector #550 could place a foot under the heater and raise the cover up by several inches.

Third floor regarding windows:

On a specific day in June 2014, Inspector #550 observed a room's window ledge adjacent to a bed to have a crack and a hole the size of a dime. The upper middle screened window (of the four paned window) had duct tape around the perimeter, the window handle was broken and covered with duct tape to hold it in place.

On a specific day in June 2014, Inspector #547 observed a room to have a broken and missing window crank where the area was stuffed with paper products to prevent exposure to the outside elements, thereby preventing any person from opening or closing this window effectively. This same window's screen no longer properly fit the open space to prevent the outside elements from entering the room. The corner of the window frame had chipped paint and cracked drywall paste exposing the wooden window ledge whereby a dark brown matter had accumulated.

On a specific day in June 2014, Inspector #547 noted the wooden window ledges in the dining area were damaged and the ledges' open areas were covered by duct tape, whereby dirt and food debris had accumulated providing a surface that could not be cleaned and sanitized. The upper middle screened window (of the four paned window) had duct tape around the perimeter, the window handle was broken, exposing a sharp metal edge; the window crank was missing and the window opening mechanism lever was not connected to the base of this window, thereby preventing any person from opening or closing this window effectively. A staff reported to Inspector #547 that staff would remove the screen and pull in the window with their hands to get the opening mechanism lever to attach to the base of the outside window. A spare window crank was located in the nursing station for all windows with missing cranks.

On a specific day in June 2014, Inspector #547 interviewed the Environmental Manager who indicated he completes housekeeping audits every three months and conducts meetings with housekeeping staff every two months.

On a specific day in June 2014, Inspector #547 interviewed Environmental Manager regarding the home's expectation for housekeeping duties and reporting of damaged areas. The Environmental Manager indicated that each department has been

instructed on the process for reporting anything damaged in the Home. Non-registered nursing staff, report to the registered nursing staff on the unit who then enter a PM works electronic entry which is sent to the maintenance department.

During an interview on a specific day in June 2014, a staff informed Inspector #547 that PM Works is accessible via computer for all Registered Nursing staff. The staff further indicated if they notice any damaged areas that require repairs, they are to be entered into PM Works. The staff was aware of the baseboards and heater boxes in disrepair, indicating that (s)he did not see this as an area for fixing, as (s)he assumed this had already been reported.

On a specific day in June 2014, Inspector #547 reviewed the last 2 General Housekeeping Audits conducted by the Environmental Manager; these audits had not detected the risk areas for residents identified in this report.

During an interview on a specific day in June 2014, a staff confirmed to Inspector #547 that registered staff could view all items entered into PM Works, including the current status of this work request.

Upon review of the CNH- Alexandria 2013 Long-Term Care Satisfaction Survey, Inspector #547 noted several comments regarding housekeeping and maintenance in 11 areas that had not been reviewed with Residents' Council and Family Council to this date.

The RQI team noted that throughout the Home's resident rooms, resident shared washrooms, bathing rooms and resident care area hallways and resident lounges, the scope of maintenance and housekeeping issues was significantly widespread and could pose serious risk for potential/ actual harm to the residents of this Home. The risk of not having in place a program to identify interventions to mitigate the risk from injury was high for a resident and resulted in actual harm.

The Accommodation Services Program requires the implementation of an effective monitoring process, including sustainable guidelines regarding preventative maintenance and reporting for resident risk areas. Together this provides sufficient grounds to issue this compliance order. [s. 15. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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. (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 failed to comply with LTCHA, 2007, S.O., c. 8, s. 6 (4) in that the licensee did not ensure that the staff and others involved in the different aspects of care for the resident collaborated with each other,
(a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A resident sustained a fall twice in November 2013, once in December 2013 and once in February 2014. A review of the resident's care plan, in place before the first fall in November, indicated the resident was at low risk for falls.

During an interview on a specific day in June 2014, the Director of Care told Inspector #550 it was her expectation that the registered staff conduct a quarterly fall assessment for all residents and that it be completed as a hard copy, not in MEDecare and be kept in the resident's file.

In the resident's chart, Inspector #550 observed that the only fall assessment completed by the registered staff was done on a specific date in January 2010, following the resident's admission when the resident was identified as being low risk for falls. No other assessments were found in the chart.

During an interview on a specific day in June 2014, the Director of Care and the Physiotherapist assistant told Inspector #550 that the physiotherapy provider completed a fall assessment on all residents upon admission, on a quarterly basis for all residents in the physio program and whenever the registered staff informed them of a change in a resident's condition.

A fall assessment was completed for the resident in September 2013, in December 2013 and in March 2014 by the Physiotherapist and indicated that the resident was at high risk for falls. The latest fall assessment, completed by the Physiotherapist in May 2014, indicated the resident was now at medium risk for falls.

A review of the resident's care plan from December 2013, was the most recent care plan following the falls in November and December 2013; despite the Physiotherapist's December 2013's quarterly assessment indicating the resident was at high risk, the resident's care plan had not been amended by nursing as the nursing assessment kept the resident at a low risk for falls. Despite the Physiotherapist's March 2014's quarterly assessment indicating the resident was at high risk, the resident's recent care plan in March 2014 kept the resident at a low risk. The most recent dated June 2014 still indicated the resident was at low risk for falls, despite the Physiotherapist's quarterly assessment in May 2014, indicating that the resident was now at a medium risk.

On a specific day in June 2014, a registered staff told Inspector #550 that residents were assessed for falls using the Morse fall assessment tool. The Home had recently implemented this assessment form a month ago as they had noticed discrepancies in the Home's assessment tool results in comparison to the tool used by the physiotherapy provider. [s. 6. (4) (a)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (10) (b) whereby the plan of care was not reviewed nor revised when the resident's care needs changed.

A resident sustained a fall in June 2014 as a result of tripping. The resident fell onto the left side, onto the floor and sustained a small laceration above the eye and complained of pain in the arm. The resident was treated with first aid by the registered staff and was transferred to the local hospital via ambulance for further assessment.

The resident's injuries were assessed in hospital, x-rays reported a displaced fracture with no other abnormalities. Steristrips were applied to the small laceration above the eye, while a cast splint was applied with tensor bandage to the resident's arm, supported by the application of a sling; the resident was returned to the LTCH. Head injury routine was initiated upon return from hospital, as per LTCH's policy and a Falls Incident Report and Post Falls Investigation report was initiated.

The current paper plan of care for the resident dated February 2014 had handwritten updates entered for February 2014 and May 2014; the MEDecare plan of care indicated a date of May 2014. There was no mention about the specific fracture in the care plan nor did it provide clear and specific interventions for this resident post-fracture, in regards to pain management and control, assistance with the resident' s needs and ADLs or care related to a fracture (i.e. color, movement, sensation of the fingers in the left hand), the proper support of the cast splint with tensor bandage and application of sling. Inspector #546 observed the resident on a specific day in June 2014 ambulating in the hall not wearing the sling and reminded the PSW to ensure that the sling was to be worn to support the cast splint and decrease swelling in the fingers and decrease pain to the fracture site; this was not noted in the plan of care.

The Falls Incident Report and Post Falls Investigation report signed and dated June 2014 by the Director of Care was not completed as indicated and did not result in a Falls Risk Assessment Tool being completed, nor the resident's care plan reviewed or updated, nor did a Physio referral occur for this resident.

As of a specific date in June 2014, the following had not yet been completed as directed: Falls Risk Assessment Tool (for residents at low or medium risk prior to this fall), Falls Prevention Care Plan reviewed and updated, PT referral completed. The

date of the only Falls Risk Assessment Tool (form #61M) completed was in February 2013; this tool stipulated that it was to be completed upon Admission, Quarterly and for HSC/Return from Hospital. During an interview with Inspector #546 on a specific date in June 2014, the Director of Care confirmed these items were not completed as directed.

On the last day of the inspection in June 2014, Inspector #546 observed that the plan of care had yet to be amended several days post-fracture in relation to pain, care, and ADLs, even though the resident's medication administration record reflected the resident was receiving acetaminophen 325mg 1-2 tablets q4h prn, as per medical directives only. [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 whereby staff and others involved in the different aspects of care of the resident shall collaborate with each other, so that (a) their assessments are integrated and are consistent with and complement each other; and (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;
and to ensure that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 8 (1)(b) in that 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, is complied with.

In accordance with O. Reg. 79/10 s. 30 (1) 1. and O. Reg. 79/10 s.48 (1) 1. and O. Reg. 79/10 s. 49. (1) (2) (3), the licensee is required to have a falls prevention and management program that includes a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for referral of residents to specialized resources where required. The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids; and the home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The Director of Care gave Inspector #550 a copy of the Home's Falls Prevention policy in the LTC-Resident Services Manual, Index I.D. RSL-SAF-055, effective July 25, 2011. Procedure #2 of this Policy indicates "On admission, quarterly and post hospitalization readmission and/or as a result of a related significant change of status, the RN/RPN and PT will assess and document the resident's risk for falls and reflectively update the plan of care."

During an interview on a specific day in June 2014, the Director of Care told Inspectors #550 and #546 that it was her expectation that the registered staff conduct a fall assessment for all residents on admission, quarterly and post hospitalization readmission and/or as a result of a related significant change of status. The falls assessment done by the registered staff are to be completed as a hard copy, not in MEDecare and are to be kept in the resident's file. The Director of Care told Inspector #550 that if the assessments were not found in the residents' chart, they were not done by the registered staff.

On a specific day in June 2014, a registered staff told Inspector #550 that residents

were assessed for falls by the registered staff upon their admission and afterwards if there is a risk or an incident. The staff, who is part of the falls management program, indicated to Inspector #550 the Falls' team met on a monthly basis and the staff reported being responsible for reviewing all falls incident reports every two weeks; these reports would be discussed later at their fall meeting and any changes would be communicated to the staff and implemented thereafter. Registered staff is to complete a fall assessment for all new admissions, when there is a change in the resident's condition, when a resident returns from a hospital stay and quarterly and when a resident has a fall. Those assessments are completed as a paper copy and are kept in the residents' charts.

A resident sustained a fall in June 2014 resulting in a fracture. Inspector #546 observed the Falls Incident Report and Post Falls Investigation report signed and dated June 12, 2014 by the Director of Care was not completed as directed; as of a specific date in June 2014, the following have not been completed as directed: Falls Risk Assessment Tool (for residents at low or medium risk prior to this fall), Falls Prevention Care Plan reviewed and updated, PT referral completed. The date of the only Falls Risk Assessment Tool (form #61M) completed was in February 2013; this tool stipulated that it was to be completed upon Admission, Quarterly and for significant change / return from Hospital.

As such, the Home does not follow their established Falls Prevention policy in the LTC-Resident Services Manual, Index I.D. RSL-SAF-055 which indicates "On admission, quarterly and post hospitalization readmission and/or as a result of a related significant change of status, the RN/RPN and PT will assess and document the resident's risk for falls and reflectively update the plan of care. The Home's policy for falls prevention and management program does not comply with the Act in fully describing the program's methods used to reduce risk and monitor outcomes, including protocols for referral of residents to specialized resources where required; the Home's policy does not comply with the applicable requirements under the Act in the provision of strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches. (546) [s. 8. (1) (a),s. 8. (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 the Falls Prevention and management program's plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
(b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 13 in that the licensee of the home did not ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

On June 12, 2014 Inspector #550 observed the following:

a. in a resident's room (a two-bed room), the privacy curtain was not wide enough to sufficiently ensure full privacy. When the privacy curtain on the side of the bedroom door was drawn, it fit only that side of the bed leaving the area at the foot of the bed fully exposed. There were unused clips at the other end of the privacy curtain track preventing the curtain from going all the way to the end of the track when pulled from that side. There was a privacy curtain between the two beds that fit properly to ensure privacy between the two beds.
b. in a resident's room (a two-bed room), there was only one privacy curtain between the two beds. When it was drawn, the privacy curtain was not wide enough to fit the track, thereby leaving an opening of approximately 12 inches, thus not ensuring the resident's privacy. There were no curtains on the side of the window that would cover the foot and the other side of the bed.
c. in a resident's room (a four-bed room), the privacy curtain near the closet did not close properly to ensure privacy for the resident. There were several extra clips

attached at the end of the track preventing the curtain from closing properly when completely drawn, thereby leaving an open area of approximately 16 inches between the end of this privacy curtain and the privacy curtain between the two beds.

On a specific day in June 2014, Inspector #547 observed in a resident's room (a two-bed room), that the privacy curtain did not completely offer privacy for the resident. There was only 1 privacy panel that, when pulled, did not offer the resident privacy as the foot of the bed was exposed.

On a specific day in June 2014, Inspector #550 and the Administrator observed during a walkabout, that a new panel of privacy curtain was added for this resident over the week-end. When all privacy curtains were drawn, they were still not wide enough to offer full privacy; there was still a 27 inches wide opening. When Inspector #550 pulled the curtains to close them, the clips were stuck in the track and would not allow for the curtain to glide either way. One of the clips fell to the floor with the curtain hook. The Administrator told Inspector #550 that the track would be replaced or repaired to ensure the privacy curtains close and open properly.

During the same walkabout with the Administrator, Inspector #550 showed him all of the identified issues in the rooms mentioned above. [s. 13.]

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 every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy for each resident, to be implemented voluntarily.

WN #5: 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 comply with LTCHA 2007, S.O. 2007, c.8, s. 57 (2) in that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On a specific day in June 2014, the President of Residents' Council confirmed during an interview with Inspector #546 that the Residents' Council did not receive written responses within 10 days from the Administrator when there was a concern or recommendation brought forward by residents at Residents' Council.

During the interview with the President of Residents' Council, the President reported a few issues. Following Inspector #546's review of Residents' Council minutes for 2013 and 2014, some of the issues mentioned by the President of Residents' Council were documented in the minutes, but there was no evidence of any written responses from the Administrator within 10 days when the concern was brought forward by residents at Residents' Council. It is important to note that the Home's Residents' Council meets every 2 months.

The Administrator informed Inspector #546 that he has never submitted written responses within 10 days to Residents' Council in regards to their concerns or recommendations, as it is not his practice. [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 the powers of Residents' Council are respected and followed as stipulated in s. 57 (8) of the Act, whereby the Council will report to the Director any concerns and recommendations that in the Council's opinion ought to be brought to the Director's attention, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 64, whereby persons involved in the management or operation of the home attend Family Council meetings regularly, without invitation.

On a specific day in June 2014, during a meeting with members of the Family Council, those present confirmed to Inspector #546 that the Director of Care schedules and attends all Family Council meetings.

On a specific day in June 2014, the Director of Care confirmed to Inspector #546 that at every meeting she has suggested to the Council to take the lead.

On a specific day in June 2014, the Administrator confirmed to Inspector #546 that the Director of Care was present at every meeting of Family Council, without any invitation. The Administrator says it has been this way for many years.

Upon review of the Family Council Meetings' minutes, there was evidence of the Director of Care reminding Family Council members and offering them to take the lead as a Council, but there was no evidence of offering external support from resources such as Family Councils' Program of Ontario documented in the Council minutes. [s. 64.]

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 whereby the licensee of the long-term care home shall attend a meeting of the Residents’ Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents’ Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 67 in that the licensee has not consulted regularly with the Residents' Council at least every three months.

On a specific day in June 2014, the President of Residents' Council confirmed during an interview with Inspector #546 that the Administrator/designate does not meet regularly with Residents' Council or at least every three months. The President stated that the Administrator was not available.

On a specific day in June 2014, the Administrator confirmed to Inspector #546 that the Administrator/designate did not meet regularly with the Residents' Council or at least every three months, as he said he thought he could not attend unless he was invited. [s. 67.]

2. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 67 in that the licensee has not consulted regularly with the Family Council, in any case at least every three months.

On a specific day in June 2014, the members of the Family Council confirmed during an interview with Inspector #546 that the Administrator does not consult with Family Council, as they receive their information from the Director of Care at all of their meetings.

On a specific day in June 2014, the Administrator confirmed to Inspector #546 that as the licensee's representative, the Administrator does not meet regularly with the Family Council or at least every three months, as he said he thought he could not attend unless he was invited. [s. 67.]

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 whereby the licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, and in any case shall consult with them at least every three months,, to be implemented voluntarily.

WN #8: 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 comply with O. Reg 79/10, s. 129 (1)(a)(i) and (1)(b) in that the licensee did not ensure that, drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and that controlled substances were not stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an observation of the medication refrigerator that was not locked in the medication room, Inspector #550 observed:
-a bottle of diet Pepsi
-2 jars of Caesar salad dressing
-5 vials of Lorazepam 4mg/ml labeled for a resident
-9 vials of Lorazepam 4mg/ml labeled for a resident
-3 vials of Lorazepam 4mg/ml labeled for a resident
-2 vials of Lorazepam 4mg/ml labeled for emergency stock

During an interview, Registered staff told Inspector #550 they were aware that all controlled substances had to be stored in a double-locked area but were unsure of how to do this since Lorazepam injectable needed to be refrigerated.

A registered staff told Inspector #550 being unaware that only drugs and drug related supplies were to be kept in the medication refrigerator. The staff also indicated to Inspector #546 that the bottle of diet Pepsi and Caesar salad dressing belonged to staff and were not for residents' use. [s. 129. (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 whereby the 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, and
(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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs; O. Reg. 79/10, s. 136 (1).
(b) all drugs with illegible labels; O. Reg. 79/10, s. 136 (1).
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 136 (1).
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and

composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 136 (1) whereby the Home failed to ensure, as part of the medication management system, that a written policy was developed in the home providing for the ongoing identification, destruction and disposal of,
a) all expired drugs;
b) all drugs with illegible labels;
c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
d) a resident's drugs where, (i) the prescriber attending the resident orders that the use of the drug be discontinued, (ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or (iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128.

Inspector #550 reviewed the Home's Disposal of Medications policy, Index I.D. RSL-MED-035, effective January, 2010. The Home's policy standard stated "Surplus drugs will be removed from current medication supplies and will be destroyed according to applicable legislation and Ministry of Health guidelines." The procedure #1. "Surplus Drugs" includes all of the following:
1.1 Individual resident's meds, which have been discontinued,
1.2 Government stock, which has become outdated.

There are no provisions in the Home's policy for all expired drugs, all drugs with illegible labels, all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies

Regulation Act, a resident's drugs where the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128.

During an interview on a specific day in June 2014, the Director of Care confirmed to Inspector #550 that the Home's policy did not reflect the legislation. [s. 136. (1)]

2. The licensee failed to comply with O. Reg. 79/10, s. 136 (2) 2., whereby the Home's drug destruction and disposal policy did not provide for any controlled substance(s) awaiting to be destroyed and disposed of to be stored in a double-locked storage area within the Home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

A registered staff told Inspector #550 that all controlled substances, that were discontinued or no longer in use, were kept locked in the locked compartment within the medication cart with all of the other controlled substances until the pharmacist came to destroy them, which is usually done on a weekly basis. They were not kept separate from other controlled substances that were available for administration to residents.

A registered staff told Inspector #550 during an interview on a specific day in June 2014, that all the controlled substances, that were to be destroyed, were kept in the locked compartment within the locked medication cart along with other controlled substances that were available for administration to residents until they are destroyed by the pharmacist. They were not stored in a separate area.

The Director of Care provided Inspector #550 with the Home's Disposal of Medications policy, Index I.D. RSL-MED-035, effective January, 2010. The Home's procedure #3 indicates "Keep narcotic and controlled drugs separate. They are to remain under double lock and counts are to continue at shift change until the pharmacist performs drug destruction." The Home's policy did not indicate that they were to be kept separate from other controlled substances that were available for administration to residents. [s. 136. (2) 2.]

3. The Licensee failed to comply with O. Reg. 79/10, s. 136 (3)(a)(b) whereby drugs must be destroyed by a team acting together and composed of,

a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) a physician or a pharmacist; and
b) in every other case, (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).
For the purposes of this section, a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On a specific day in June 2014, a registered staff indicated to Inspector #550 that when a drug, that was not a controlled substance was being discontinued or no longer in use, the registered staff, who was disposing of the drugs, would fill out the surplus drug form and place the drugs in their original packaging in the white pail kept in the locked medication room for this purpose. When the pail was full, it was sealed and sent to the pharmacy to be destroyed. The drugs were not denatured or altered.

On a specific day in June 2014, during an interview, the Director of Care indicated to Inspector #550 the Home’s process for drug destruction was: when a drug that is not a controlled substance was no longer used or was discontinued, the RN/RPN on duty would fill out the surplus medication sheet and place the medication in the white plastic container located in the medication room. When the pharmacist came to the Home, the pharmacist would co-sign the surplus drug sheet(s), would seal the container and the container was then stored in the medication room until Stericycle came to remove it from the Home. The Director of Care indicated to Inspector #550 she was unsure if the controlled and non-controlled substances were denatured or altered by the team. The Director of Care gave Inspector #550 a copy of the Home's Disposal of Medications policy, index I.D. RSL-MED-035 where it is indicated under #7. that the Home's procedure is "The Director of Care/delegate will witness the drug destruction with the Pharmacist."

On a specific day in June 2014, the Home’s Pharmacist (from Pulse RX LTC pharmacy, the Home’s pharmacy provider) reported to Inspector #550 coming to the Home on a weekly basis to destroy the medications. The nurse on duty would give the Pharmacist the container of the non-controlled drugs to be destroyed with the surplus drug sheets filled out by registered staff. The Pharmacist would then sign the surplus drug sheets and give them to the DOC to co-sign. The Pharmacist then

sealed the container containing the non-controlled drugs and left it in the locked medication room until Stericycle came to pick it up. The Pharmacist told Inspector #550 that the drugs left the Home in a whole state, that they were not denatured or altered. The Pharmacist indicated the nurse on duty would give the Pharmacist the controlled drugs that were to be destroyed. The Pharmacist would count them and sign the narcotic drug count sheet. The controlled substances were then removed from their packaging and placed in a container separate from the non-controlled drugs. The pharmacist then brought that container to the other floor to perform the drug destruction on the other floor. It is only before The Pharmacist left the Home that the Pharmacist would independently denature/alter the drugs by pouring a liquid (usually Lactulose) over the medication. [s. 136. (3) (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 whereby the licensee shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs;
(b) all drugs with illegible labels;
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128.

and, in that the home's drug destruction and disposal policy does not provide that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (3) in that the licensee did not seek the advice of the Residents' Council and Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Residents' Council President, on a specific day in June 2014, the President indicated that the Home did not always seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and could not recall when Council's advice was formally sought for their input or act on the survey's results. The President further added being told by the Council assistant that the survey results for 2013 were out but Residents' Council had yet to hear of them. The President could not recall when the last Residents' Council meeting was held.

During an interview with the Administrator on a specific day in June 2014, he indicated that there was no formal process with Residents' Council or Family Council to develop any pre-survey questions. He indicated that the process used in developing and carrying out the survey, had not formally involved the Residents' Council or Family Council but rather asking when out and about during meals what the residents might like to see in the satisfaction survey.

During an interview with the Administrator on a separate day in June 2014, he confirmed that following the release of the 2013 Satisfaction Survey results on January 14, 2014, he had not met with Residents' Council or Family Council (and other families at large) to discuss the survey's results and any action taken to this date. [s. 85. (3)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (4) in that the licensee did not document and make available to the Residents' Council and Family Coucil the results of the satisfaction survey in order to seek the advice of the Councils about the survey.

During an interview with the Residents' Council President on a specific day in June 2014, the President added being told by the Council assistant that the survey results for 2013 were out but Residents' Council had yet to hear of them. Family Council members confirmed in an interview with Inspector #546 that they had not received feedback on the survey results' document yet.

During an interview with Inspector #546 on a specific date in June 2014, the Administrator provided a copy of the 2013 Satisfaction Survey results and verbatim comments emitted on January 14, 2014 to management.

During an interview with Inspector #546 later in June 2014, the Administrator confirmed that he has not met with Residents' Council or Family Council to discuss, seek advice nor act on the survey's results to date. [s. 85. (4) (a)]

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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s.229(10)4. whereby staff were not screened for tuberculosis(TB) in accordance with evidence-based practices and, in accordance with prevailing practices.

On a specific date in June 2014, Inspector #547 interviewed the Director of Care who reported she was the lead for Infection Prevention and Control Program and education for the Home. The Director of Care indicated that newly staff hired were screened for TB since the new regulation came out in 2010. For staff hired prior to July 2010, no verification was required or completed if their TB testing was on file.

On June 17, 2014, Inspector #547 interviewed both the Director of Care and another staff who both confirmed that a specific staff had no screening for TB on the employee's file.

The Community Lifecare Inc. policy regarding Employee Health indicates "that each person requires proof to be tested free of TB in order to work here, and proof is to be kept on the medical file in the home. Furthermore, failure to produce the information on a positive TB test result will prevent employment here." As such, staff working in the home are not screened for tuberculosis in accordance with evidence-based practices and prevailing practices. [s. 229. (10) 4.]

Issued on this 27th day of June, 2014

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN WENDT (546), JOANNE HENRIE (550), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2014_285546_0019
Log No. / Registre no:	O-000509-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 27, 2014
Licensee / Titulaire de permis :	COMMUNITY LIFECARE INC 1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6
LTC Home / Foyer de SLD :	COMMUNITY NURSING HOME (ALEXANDRIA) 92 CENTRE STREET, ALEXANDRIA, ON, K0C-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TERRY DUBE

To COMMUNITY LIFECARE INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair including repairing, refinishing and or replacing as appropriate:

1. All damaged baseboards;
2. All damaged trim posing risks for resident injury;
3. All damaged windows and window ledges in resident care areas which have not been maintained to provide for a surface that is able to be cleaned and sanitized;
4. All damaged baseboard heaters, posing risks for resident injury;
5. All damaged walls with sharp plastic or metal edges, posing risks for resident injury;
6. All damaged roof and ceilings' leaks into the resident care areas;

Develop an effective monitoring process to ensure that areas in disrepair, posing a risk to residents, are identified through the staff reporting mechanism and assign the process for review of deficiencies to staff with supervisory responsibilities in resident care areas of the Home.

Implement an effective monitoring process by repairing, refinishing and or replacing the home, furnishings and equipment, with immediate attention to the identified areas posing a risk for resident injury in resident care areas.

Ensure that the licensee's quality assurance process evaluates the results of the implemented monitoring process and the efficiency of the actions taken to resolve the Home's deficiencies.

The plan shall identify the timelines for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Lisa Kluke by July 18, 2014 via email to lisa.kluke@ontario.ca. or submitted in writing by July 18, 2014 to Inspector Lisa Kluke, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment be

maintained in a safe condition and in a good state of repair.

During the RQI inspection, the team of LTCH inspectors made the following observations which presented an indication of widespread failure of the maintenance program, some areas, identified in WN#1 of the report, may constitute as potential risk related to resident safety.

1. Furnishings and equipment were not maintained in a safe condition and a good state of repair:

• Baseboards were observed to be damaged in rooms #207,#209, #216, #206, #303, #305,#311,#315, dining areas on both second and third floors, as well as bathing rooms on both second and third floors whereby the baseboards were cracked, no longer sealed to the wall surface, broken or missing all together. Non intact floor/wall coverings are a potential safety risk and cannot be properly cleaned or sanitized.
• Wooden trim near the servery counter in the Resident Lounge on the second floor is broken which posed a risk for residents.
• Walls and ceilings were observed to have been damaged throughout the home in rooms #202, #204, #207, #208, #209, #307, #308, #309,(including the washrooms for these rooms) dining areas on both second and third floors, as well as the bathing rooms on both second and third floors. These areas were noted to have drywall / or particle board wall surfaces that were dented, gouged, cracked or missing altogether exposing several different porous material, gaps or sharp metal framing plates in resident care areas. Non intact surfaces cannot be adequately cleaned and sanitized as required presenting a potential infection control risk. Damaged surfaces may also present a safety risk for residents as specifically identified in the bathing room on the 3rd floor for a resident who sustained a cut to the left hand from a sharp edge on the drywall. The ceiling in the third floor dining area was noted to have two areas of water dripping from the ceiling with pails for water collection beneath them, located next to resident wheelchairs sitting in this area for activities or meals. Water was noted to be leaking from the ceiling on days when it was raining outdoors presenting a safety risk for residents utilizing this area on the third floor.
• Several window and window ledges were observed to be damaged as evidenced by missing and/or broken parts for the proper functionality, including duct tape was placed over cracks and spaces as the proper sealing agent was missing in rooms #203, #207,#211, #301 #303, #305, # 307, #311, #315, dining areas on both second and third floors. These damaged surfaces were not intact

providing difficult areas to clean and sanitize. These damaged windows presented a safety risk for residents if the windows were left open to the outdoor elements, thereby creating a slip/falls issue if rain were to enter residents' rooms.
• Baseboard heaters on both second and third floors located in the dining areas, lounge area (on the second floor), and resident care area hallways were noted to be scratched and dented with sharp broken metal edges presenting a significant safety risk for residents.
• Ceramic wall tiles in resident shared washrooms near toilet paper dispensers were noted in rooms #208 and #307 to be damaged with sharp tile edges that were not maintained in a good state of repair presenting a potential safety risk for residents.
• Residents' closet doors were not installed properly, whereby the base of the closet doors were hanging or rubbing the floor as the doors were not connected to the lower track in rooms #307 and #308.
• Room 206 (vacant and ready for a new admission) had a rusted four inch by four inch area inside the middle drawer in the bedside table that was not reported for repair providing an area that could not be cleaned or sanitized.
• Resident sitting area (off the second floor elevator) had a two-seater sofa (used by residents and visitors) with a hole in the upholstery of the right seat cushion.
• Resident shared washroom #302 had a faucet that freely moved from the sink when opening and closing of the taps.
• Non intact surfaces could not be adequately cleaned and disinfected as needed, presenting a potential infection control risk. Damaged surfaces may also present a safety risk for residents.

2. A review of the last two audits conducted by the Environmental Manager did not detect any of these risk areas for residents identified in this report.

The scope of maintenance and housekeeping issues identified was significantly widespread and presents potential risks to the health, comfort, safety and wellbeing of residents of this Home. The accommodation services program requires the implementation of an effective monitoring process, with sustainable guidelines regarding preventative maintenance and reporting of damaged areas posing risk for resident injury. This provides the grounds to issue this compliance order.
(547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of June, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Susan Wendt

Service Area Office / Bureau régional de services : Ottawa Service Area Office