Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Sep 17, 2015	2015_276537_0035	019818-15	Resident Quality Inspection

Licensee/Titulaire de permis

CRAIGWIEL GARDENS
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

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

CRAIGHOLME
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

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

NANCY SINCLAIR (537), ALI NASSER (523), ALICIA MARLATT (590), NATALIE MORONEY (610)

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): August 17, 18, 19, 20, 21, 24 and 25, 2015

The following Critical Incident inspections were conducted concurrently during this inspection:
Log # 010413-15/CI 2622-000020-15 related to medication administration.
Log # 014450-15/CI 2622-000025-15 related to the allegation of abuse to a resident.

During the course of the inspection, the inspector(s) spoke with Residents, Three Family Members, the Executive Director (ED), Director of Care (DOC), Director of Environmental Services (DES), Director of Food Services, Dietitian, Pharmacist, Two Registered Nurses (RN), Three Registered Practical Nurses (RPN), Six Personal Support Workers (PSW), and Three Housekeeping/Laundry Aides.

During the course of the inspection, the inspector(s) also toured the home, observed meal service, a medication pass, medication storage areas, recreational activities and care provided to residents, reviewed health records and plans of care for identified residents, reviewed assessments, policies, procedures,meeting minutes, training records, and observed general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

- **9 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that the resident-staff communication and response system can be easily accessed and used by residents at all times.

1) Observations with the Executive Director (ED) of the public washroom across from the dining room revealed the call bell string was tied to the lower back section of the toilet seat, and when pulled by the ED the bell was not activated.

The ED confirmed that the staff communication system was not accessible. The ED untied the string and placed on the grab bar.

2) A tour of three common areas of the home revealed the staff communication system was installed in these areas at a minimum height of 49 inches, with no string attached for activation. The ED confirmed in an interview that the majority of the residents in the home would not be able to easily access and activate the call bell due to disease status, deconditioning and limited ROM.

The ED stated that the home will be contacting the company that installed the call bells and requesting strings to be attached.

The ED confirmed it is the home's expectation that the resident-staff communication and response system can be easily accessed and used by residents at all times [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 that the resident-staff communication system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

1) Review of Point Click Care documentation (PCC) revealed that an identified resident had a fall that resulted in an injury.

Further review of PCC documentation revealed that the resident did not have a post fall assessment completed.

PCC documentation showed that when the resident returned from hospital, there was no completed assessment for falls found.

The home's policy 3.6, Falls Prevention and Management, indicated that there was a two-step process that was implemented on admission to the facility, reviewed and updated with any fall or with any changes in the resident's condition:
"1. Identify the risk areas that contributed to resident's fall risk. Complete the Morse Falls Risk Assessment and identify the resident risk level.
2. Complete and fax the Primary Care Provider Report, receive the Order Sheet and make appropriate referrals. Once the Falls Assessment is complete, it should be placed in the resident's chart."

The Director of Care confirmed that a post fall assessment was not completed after the fall and that a Morse Falls Risk assessment was not completed when the resident had a change in condition related to a fall.

2) Review of Point Click Care documentation (PCC) for the Medication Administrative Record (MAR) revealed that an identified resident had a pain assessment order to be completed three times a day (TID).

Review of the MAR for the resident revealed twelve missing signature entries with no pain evaluation for an identified period of time in August 2015.

Further review of the PCC documentation showed that the resident's last pain assessment was completed in April 2015.

The home's policy 14.1, Pain Management indicated:
"All residents will be assessed and or reassessed for persistent pain, regardless of whether they are currently experiencing pain or at risk for persistent pain due to having chronic illness consistent with pain that:
Within seven days of admissions, at least quarterly, when there is a change in the residents status that affects their pain and Q shift."

The Director of Care and the Administrator confirmed that a pain assessment was not completed as per the physician order and at least quarterly.

The Executive Director confirmed that it was the home's expectation that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented to identify the residents risk level. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a policy and procedures were developed and implemented for addressing incidents of lingering offensive odours.

During stage 1 of the RQI, on three different days, an odour was noted in specified bathrooms and in the hallway, on several visits to the rooms during the time the inspectors were in the home.

An interview with a Personal Support Worker and a Registered Practical Nurse confirmed an awareness and presence of the odour.

Interview with the Director of Environmental Services indicated that the bathrooms of all residents, including the rooms identified, were cleaned daily by housekeeping and that additional cleaning products were used specifically for odour when present. The Director of Environmental Services confirmed that the odour remained following the daily cleaning.

The Director of Environmental Services confirmed that the organized program of housekeeping did not include the development and implementation of a policy and procedures for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A medication as ordered for an identified resident was found to be missing from the administered location site as indicated on the MAR.

The home's policy 7.6, Transdermal Patch Administration indicated "an incident report is to be filled out if you did not find the old patch on the resident when you went to remove it or if the patch is on a different spot than the location site indicated on the MAR."

The Director of Care confirmed that a medication incident report was not completed and that the expectation was that a medication incident report should have been documented. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #5: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug that was to be destroyed is a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. a physician or a pharmacist.

Review of a clinical record and an internal investigation report revealed that a controlled substance for an identified resident was found located on a site other than indicated on the MAR. Further review, and interview with the Director of Care revealed that the controlled substance was disposed of in a sharps container by a Registered Practical Nurse and a Registered Nurse.

The Director of Care confirmed that the controlled substance was not disposed of by a Registered Staff and a physician or pharmacist. [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 to ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. a physician or a pharmacist, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids,
a) labeled within 48 hours of admission and of acquiring, in the case of new items.

A tour with the Executive Director revealed in identified washrooms, the following personal care items to be unlabeled:
- a urinal and a wash basin, body wash, two toothbrushes

The identified personal care items were labeled in all other washrooms that were observed.

The Executive Director confirmed the home's expectation that all personal care items were to be labeled. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to report and locate residents' lost clothing and personal items.

Resident Interview during Stage 1 of the RQI revealed three residents who had reported

missing clothing and personal items, and that the items remained missing. Interviews of various staff of the home indicated that staff implemented their own approach to attempt to locate missing clothing and personal items.

An interview with the Director of Environmental Services revealed that when complaints were received about missing articles of clothing, searches should be completed of the resident's drawers and closets, including the other resident rooms on the unit if necessary; the laundry department was checked to determine if the missing article was in the process of being laundered; the lost and found checked for the missing article. If the missing article of clothing was not found the staff were to complete a complaint form and submit the form to the Director of Environmental Services for follow up and communication with the resident/family.

Interviews with three Personal Support Workers (PSW's)/Health Care Aides (HCA's) revealed that when complaints of missing articles of clothing were received, they completed searches of the resident's room including any room mates drawers and closets, checked with the Laundry Aides to see if the clothing was being laundered and also checked the lost and found for the missing item. Two PSW's indicated that a custom alert was completed in the POC system and the oncoming shift was verbally notified of the missing item; one indicated a post-it note was left at the desk with a description of the missing item. All three were unaware of a complaint form which should be filled out and submitted to the Laundry Manager.

Three Housekeepers/Laundry Aides were interviewed. Two of the three staff members revealed that when complaints of missing articles of clothing were received, searches of the resident's room were completed, including any room mates drawers and closets and the lost and found was checked for the item. All three indicated they were not aware of a form to be filled out when missing items could not be found, but indicated the Laundry Manager would be verbally notified of the missing item.

The Director of Environmental Services verbalized that the home needed to develop a consistent process for locating missing clothing and personal items and communicate and educate the staff of the process.

The Director of Environmental Services confirmed that there was no written procedure or policy for lost articles of clothing and that the organized laundry program does not address resident's missing articles of clothing. The Executive Director revealed a Draft policy that had been written as a result of this issue and confirmed that the staff would be

educated on the new process. [s. 89. (1) (a) (iv)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

1) During the initial tour of the home, a soiled utility room door was found to be unlocked. This door had a sign on the door indicating "This door is to be locked at all times". The inspector observed items in the room which contained three easily accessible bottles of sporocidal liquid/disinfectant cleaner.
A Housekeeping/Laundry Aide confirmed the soiled utility room doors were to be locked at all times, confirmed the hazardous items were accessible to residents, and ensured the door was locked.

2)Observation revealed that the housekeeping cart was left in the hallway by the nursing station unattended, the top section of the cart was unlocked and it contained one bottle of Crew Super Blue (mild acid bowl cleaner), one bottle of Glance (window and surface cleaner) and one bottle of Virex.

During this time, several residents were observed passing by the cart.

The housekeeping staff returned to the housekeeping cart and confirmed that the top section was unlocked and contained bottles of hazardous substances. The staff member attempted to lock the cart, and indicated that the lock was broken and had not been working for a while and was previously reported to the manager.

The Director of Environmental Services (DES) confirmed that the lock was not working and that the hazardous substances were accessible to residents. The DES moved all hazardous substances to the lower section of the cart where it would be locked.

The DES confirmed that it was the home's expectations that all hazardous substances would be kept inaccessible to residents. [s. 91.]

WN #9: 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 has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

An observation was conducted of the medication room on the upper and bottom home areas. The medication room on both home areas was locked when entering the medication room. The fridge on both home areas was found to be unlocked with controlled substances of Lorazepam vials in the fridge.

The home's policy 3.8 Medication Management System for Narcotic and Controlled Medication Lock Box indicated:
"Narcotics and controlled drugs must be kept in the designated drawer of the medication cart or in the separate, double locked stationary cupboard in the locked med room."

The Nurse on the upper home area confirmed that they do not lock the fridge in the medication room that has controlled substances.

The Director of Care confirmed that she did not have a key to lock the fridge that had controlled substances in the fridge.

The Administrator confirmed that it was the home's expectation that controlled substances would be in a double locked stationary area. [s. 129. (1) (b)]

Issued on this 17th day of September, 2015

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

Original report signed by the inspector.