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
Feb 5, 2015	2015_413500_0002	T-1655-15	Resident Quality Inspection

Licensee/Titulaire de permis

SLOVENIAN LINDEN FOUNDATION
52 NEILSON DRIVE ETOBICOKE ON M9C 1V7

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

DOM LIPA
52 NEILSON DRIVE ETOBICOKE ON M9C 1V7

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

NITAL SHETH (500), JOELLE TAILLEFER (211), SLAVICA VUCKO (210)

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): January 29, 30, February 2, 3, 4, 5, 2015.

The following complaint inspections were completed during this RQI: T-528-14, T-1805-15.

During the course of the inspection, the inspector(s) spoke with the administrator,Director of Care (DOC), residents care coordinator (RCR), activation coordinator, food service manager, physiotherapist (PT), registered nursing staff, personal support workers (PSWs), private care giver, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity of residents are fully respected and promoted.

Interview with the private care giver of resident #11 indicated that on December 2014, he/she was walking with the resident using a walker. They entered in the library. The private care giver found one of the PSW laying on two chairs using arms as a pillow to hold up his/her head and appeared to be sleeping. The resident started shuffling the chairs. The PSW jumped to his/her feet quickly and went to walk pass by the resident pushing his/her hip to the resident's right side and left the room and made the resident upset. Resident did not loose his/her balance.

A review of the home's investigation report and interview with the administrator indicated that the PSW was not being respectful to the resident during the above mentioned occurrence. [s. 3. (1) 1.]

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 has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspect of care are integrated and are consistent with and complement each other.

On January 29 and February 2, 2015, the inspector observed that resident #1 was wearing socks and booties on both feet while sitting in the geriatric chair.

Interview with the identified personal support worker (PSW) revealed that the resident wears the socks and the booties only when he/she is sitting in the geriatric chair because of skin sensitivity. He/she revealed that the unit communication book on August, 2014, indicated that resident should wear the booties however it was not documented in the current written plan of care.

Record review of the unit communication book confirmed that the resident should wear booties.

However, review of the current written plan of care indicated that the resident may be at risk for potential skin alteration and does not indicate any mention of the resident having to wear booties.

Interview with the resident care coordinator (RCR) revealed that the application of the booties was initiated on March 2014 because the resident had developed a pressure area on the foot related to an identified disease. On April 2014, the skin in that area was resolved and the intervention was removed from the written plan of care. He/she confirmed that the resident is wearing the booties while sitting in the geriatric chair but there was a lack of communication between the PSW and the registered staff. The application of the booties should be in the written plan of care. [s. 6. (4) (b)]

2. The licensee has failed to 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, the resident's care needs change or care set out in the plan is no longer necessary.

A review of a plan of care revealed that resident #5 has impaired vision and staff needs to ensure that the glasses are clean and being worn by the resident during reading.

Interview with the PSW and registered nursing staff confirmed that the resident does not read or use glasses anymore. An identified Registered Practical Nurse (RPN) confirmed that the family took the glasses at home.

Interview with the registered nursing staff confirmed that the plan of care needs to be revised as the resident does not use glasses anymore.

Interview with the administrator confirmed that the plan of care needs be to revised for the above mentioned resident for glasses not being used. [s. 6. (10) (b)]

WN #3: 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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observation performed on February 3, 2015, at 2:25 p.m., of the medication cart, narcotics box, revealed a presence of an envelope and keys, together with the narcotics.

Interview with the identified registered nursing staff indicated that the envelope was kept in the narcotics box because it was waiting to be given to a resident's family, and that the narcotics box is a safe place to keep "things".

The identified registered nursing staff confirmed that he/she was not aware that nothing else but narcotics should be kept in the narcotics box. [s. 129. (1) (a)]

Issued on this 5th day of February, 2015

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

Original report signed by the inspector.