Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 11, 2014	2014_198117_0010	O-000192-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE MEDEX
1865 BASELINE ROAD, OTTAWA, ON, K2C-3K6

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

LYNE DUCHESNE (117), ANANDRAJ NATARAJAN (573), RENA BOWEN (549), WENDY PATTERSON (556)

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): March 24, 25, 26, 27, 28, 31 and April 1, 2, 2014

Three other inspection logs related to one complaint (Log # O-000013-14) and two critical incidents (Logs #O-000073-14 and #O-000187-14) were conducted during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), two Assistant Director of Care (ADOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Food Service Manager, several Dietary Aides, Housekeeping and Laundry Aides, Support Services Manager, maintenance staff, several Residents, several Resident Family Members, President of the Resident Council and both Co-Chairs of the Family Council.

During the course of the inspection, the inspector(s) reviewed several resident health care records; observed lunch time meal service of March 24, 2014; observed beverage and snack passes on March 24 and 25, 2014; observed provision of resident care and service; observed staff-resident interactions as well as resident-resident interactions; examined resident rooms and common areas; reviewed 2 Critical Incident Reports; reviewed the following home policies : Resident's Abuse to Resident #OPER-02-02-04 version November 2013; Self Administration of Medication September 2010; Responsive Behaviours #09-05-01; Responsive Episode Debriefing Policy; Post Fall Assessment #RESI-10-02-02 April 2013; Infection Control Program; Reports and Complaints June 2010 and Palliative Care RESI-04-04-06; reviewed 2013 Learning Fair Education Agenda and staff attendance; the registered nursing staffing schedule; the home's Capital Replacement Plan 2012-2016, Maintenance Yearly Larger Project Plan 2014, the Maintenance Wall & Ceiling Repair Schedule as well as the Commode & Deep Cleaning Furniture Schedule.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
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
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, S.O. 2007, Chapter 8, s. 3 (1) (4) every resident has the right to be properly groomed and cared for in a manner consistent with his or her needs. (Log # O-000187-14)

A review of Resident #2's health care record was conducted. It is noted that Resident #2 has cognitive impairments and requires full staff assistance for the provision of his/her care. The chart as well as a Critical Incident, documents the following incident.

On a specified day in February 2014, a staff member #S132 entered Resident #2's room at approximately 09:15am to clean the room as requested as there was diarrhea and vomit on the floor and the walls. Staff member #S132 indicated the vomit and stool was dried and it was apparent it had been there since the evening and night prior. Once done at approximately 10:50 am # S132 went to the Assistant Director of Care's (ADOC) #S101 office to inform the ADOC of the condition of Resident #2 and the room.

At approximately 11:00am, the ADOC # S101 went to the second floor to Resident #2's room. ADOC # S101 found Resident #2 in bed with visible amounts of stool and vomit on Resident #2's linens and clothing. Resident #2's back and catheter had a large amount of dried stool and his/her incontinent product was full of stool and heavy. Resident #2 was upset and in pain as documented on the Critical Incident Report.

The home conducted an investigation of the incident and the following was disclosed in signed staff statements.
• Resident #2 was ill throughout the night shift of a specified date in February 2014.
• The next morning RPN #S131 was notified by PSW #S133 that Resident #2 had diarrhea. RPN #S131 indicated Resident #2 was not assessed until somewhere between 9:30am and noon.
• RPN #S131 acknowledged she was informed that Resident #2 had vomited on the linen and on the floor.
• RPN #S131 indicated PSW #S133 was directed to clean the floor and change the linen at approximately 9:30am.
• RN #S117 indicated to the ADOC# S101 that she was aware that Resident #2 was ill but did not assess the resident as the privacy curtain was drawn when rounds were made at 7:30am.
• The home's investigation documentation indicated that ADOC# S101 felt that Resident #2 had been in this condition for some time

On March 31, 2014, the home's Administrator and DOC stated to Inspector #546 that Resident #2 was not provided the necessary care until approximately 11:00am on a specified date in February 2014, when the housekeeping staff reported to the ADOC# S101 the concern for Resident #2.

The home's registered nursing staff failed to assess Resident #2 after he/she had been ill and provide care in a manner consistent with his/her needs on a specified date in February 2014. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when acute changes in a resident's condition is brought to the attention of registered staff, that the registered staff immediately go and assess the resident and provide care to the resident in a manner consistent with his or her needs, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, C. 8, s. 6. (1) (c) in that the licensee did not ensure that there is a written plan of care for an identified resident that sets out clear directions to staff and others who provide direct care to the resident. (Log# O-000013-14)

A review of Resident #1's health care record was conducted. Documentation indicates that Resident #1 returned from hospital on a specific day in December 2013 with Palliative Care orders. Palliative Care orders were verified by the attending physician. Resident #1 was confined to bed and was at end of life status. Resident #1 passed away 3 days after his/her return from hospital.

A letter addressed to the Director of Care from the resident's family member dated five (5) days after Resident #1's death, stated that when they came to visit 2 days after the resident's return from hospital, Resident #1 looked like no one was taking care of the resident; the resident was not groomed, mouth full of mucous and the resident had slid to the bottom of the bed with his/her feet against the foot board.

It was noted that Resident#1's written plan of care was not updated upon his/her return from hospital. It did not reflect that the resident was bedridden, requiring end of life care. It stated the following:
• "The resident requires limited to extensive assist for toileting. Staff to provide pericare but resident actively involved with other aspects of toileting."

• "Resident #1 has a red area over coccyx, potential for pressure ulcers d/t incontinence r/t dementia and physical decline. Post hospital acquired pressure ulcers Stage 2 and Stage X . The intervention is to apply a medicated cream as prescribed by MD." It is noted that the medicated cream was discontinued on a specific date in October 2013.

• "Ambulates with a walker, supervision or limited assistance of one staff, walks in the corridor, extensive assist with dressing.

On March 30, 2014 Inspector #549 reviewed the Point of Care (POC) documentation for Resident #1 from the month of December 2013. It indicated that PSW staff continued to provide care to the resident as per the unchanged plan of care, which was not reflective of Resident #1's care needs at that time.

Inspector #549 reviewed the nursing progress notes for December 2013. One progress note written on a specific day in December 2013 stated resident was repositioned every 2 hours on the evening shift. There was no documentation on the POC to support that Resident #1 was repositioned every 2 hours from the time the resident returned from the hospital to his/her passing

The home conducted an investigation into this incident. Several of the PSWs assigned to Resident #1 wrote in signed witness statements that they did not have palliative care training and that they were not aware of the end-of-life care needs for Resident #1.

During a discussion on March 31, 2014 the Administrator and Director of Care indicated to Inspector #549 that direct care staff are not given clear directions as to what care is to be provided for residents who require end-of-life care.

The written plan of care was not updated to reflect palliative care goals and interventions to meet the needs of Resident #1. The direct care staff was not given clear directions to be able to provide care for Resident #1. [s. 6. (1) (c)]

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 written plan of care for residents that are at end of life, is updated, is reflective of the residents needs and set out clear palliative care direction to staff and and others who provide care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 17 (1) (a), in that the home did not have a resident-staff communication response system (the system) that can be easily seen, accessed, and used by residents, staff and visitors at all times.

On March 26 and 27, 2014, Inspectors #573 and #117, observed Resident #325's bed side resident-staff communication response system (the system) to be looped over and around the over bed light. The system was not easily accessible for resident use. On March 27, Resident #325 indicated to Inspector #117 and PSW #S110 that it was a staff member who had placed the system up and around the over bed light. Resident #325's plan of care indicates that the resident-staff communication response system needs to be within resident reach. PSW #S110 stated to Inspector #117, that the system should be placed and clipped on the resident's bed in such a way as the system can be seen and be accessible at all times. At that time PSW #S110 intervened and repositioned the system so that it was easily seen and accessible to the resident. [s. 17. (1) (a)]

2. On March 26, 2014, Resident #268 was observed by Inspector #556, lying on the bed with his/her head at the foot of the bed and his/her feet at the head of the bed where the resident had been placed by the staff after being assisted up from the floor after experiencing a fall. The Resident #268 was alone in the room and the resident-staff communication response system (the system) was behind the headboard on the floor, well out of reach of the resident.

On March 26, 2014, and March 27, 2014, Resident #288 was observed by Inspector #556, to be in his/her room, in his/her wheelchair, parked in the center of the room. On both occasions the system was at the head of the bed out of reach, at least five feet away from the resident.

In an interview PSW #S112 stated that Resident #288 is not capable of activating the system and therefore he/she does not think to put the system within the resident's reach.

In an interview RN #S123 stated that the resident-staff communication response system is to be within reach at all times when a resident is in their room even if the resident is not capable of activating the system because a staff member, or a family member, may need to use the system to summon assistance.

In an interview the Director of Care (DOC) stated that it is an expectation that all

residents are to have the system accessible to them at all times, whether the resident is capable of activating the system or not. [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 and response system can be seen and be accessible to all residents at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 24 (1) 2, in that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, did not immediately report the suspicion and the information upon which it was based to the Director regarding an incident of 2) Abuse of a resident by anyone that resulted in harm or risk of harm. (Log #O-000078-14)

As per O.Reg. 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

During a review of Resident #3's health care record, in relation to a critical incident dated in January 2014, it was noted that an incident of alleged sexual abuse was documented in the resident's chart.

On a specific date in December 2013, Resident #3 was observed to have allegedly sexually abused another resident. An RPN #S135 observed Resident #3 holding a resident's hands and then touch his/her breasts. The RPN #S135 immediately intervened and separated both residents. Chart documentation indicates that the DOC was notified immediately, the home immediately investigated the alleged incident of sexual abuse and notified the required parties.

However, there is no information in the resident's health care record or the home's documentation to indicate that the incident of alleged sexual abuse was immediately reported to the Director, as per legislative requirements.

On March 31, 2014, the home's DOC and ADOC #S102 stated to Inspector #117 that they had not reported the alleged incident of sexual abuse to the Director, as per legislative requirements. [s. 24. (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 a person who reasonable grounds to suspect that all incidents of alleged sexual abuse, are immediately reported to the Director, as per legislative requirements, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 42 in that the licensee did not ensure that every resident who requires end-of-life care receives end-of-life care in a manner that meets their needs. (Log # O-000013-14)

A review of Resident #1's health care record was conducted. Documentation indicates that Resident #1 returned from hospital on a specific dated in December 2013 with Palliative Care orders. Palliative Care orders were verified by the attending physician. Resident #1 was confined to bed and was at end of life status. Resident #1 passed away three days later.

Two days after the resident's return from hospital, Resident #1's family members came to the home to sit with Resident #1.

Resident's family member stated in a letter addressed to the Director of Care (DOC), dated five days after the resident's passing, that when he/she came to visit, he/she found Resident #1 un-groomed, he/she had slid to the bottom of the bed with his/her feet against the foot board and his/her mouth was full of mucous. The family member stated in the letter that it looked like no one was taking care of the resident.

The home investigated the incident on a specified day in January 2014. The documentation from the home's investigation states that on the day of the family's visit, during the evening shift RPN #S120 and PSW #S121 where requested by Resident #1's family member to provide care to the resident. RPN #S120 and PSW #S121 found Resident #1 in bed un-groomed, mouth full of mucous and the resident had slid to the bottom of the bed. PSW #S121 stated during the investigation the resident appeared to have facial hair growth of at least 2 to 3 days.

The home's investigation documentation indicated that PSW #S124 who was assigned to Resident #1 did not shave Resident #1 on specified day in December 2013. RPN #S120 indicated that it appeared that mouth care had not been done for at least 3 days.

The home conducted an investigation into this incident. Several of the PSWs assigned to Resident #1 wrote in signed witness statements that they did not have palliative care training and that they were not aware of the end-of-life care needs for Resident #1.

During a discussion on March 31, 2014 the Administrator and Director of Care indicated to Inspector #549 that direct care staff are not given clear directions as to what care is to be provided for residents who require end-of-life care. [s. 42.]

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 a plan be developed for the provision of end of life care and that education be given to staff in regards to the provision end of life care based on individual resident needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care 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. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 49. (2) in that when Resident #268 and Resident #165 fell, the residents are assessed and where the condition or circumstances of the resident require, a post-fall assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) Resident #268 is identified as being at high risk for falls. A review of the progress notes on Resident #268's medical record indicate that on three specified days, one in

December 2013, once on two consecutive days in March 2014, Resident #268 experienced a fall. The resident sustained an injury when he/she fell on the second specified day in March 2014. No Post Fall Assessments were noted to be on the resident's medical record for any of these falls.

The DOC reviewed the medical record of Resident #268 with Inspector #556, and also looked in the home's Risk Management documentation, and stated that the post fall assessments for the falls experienced by Resident #268 on the three specified days in December 2013, and March 2014, were not completed.

B) A review of the progress notes on Resident #165's medical record indicate that on a specified day in March 2014, Resident #165 experienced a fall resulting in a fracture of a digit, however there is no post fall assessment to be found on the resident's medical record related to the fall.

The Assistant Director of Care #S101 reviewed Resident #165's medical file with inspector #556, and also the home's risk management documentation, regarding the fall and injury sustained by the Resident #165 on a specified day in March 2014, and stated that the post fall assessment was not done, although it is supposed to be done following every fall as per the home's policy.

In an interview RN #S123 stated to Inspector #556 that when a resident falls, once the initial assessment of the resident has been completed, a registered staff completes the post fall assessment. Staff Member #S123 further stated that the purpose of the post fall assessment is to determine what caused the fall so that interventions can be put in place to prevent further falls. The home's DOC confirmed to Inspector #556 that staff #S123 description of the post-fall assessment process and tool are as per the home's Post Fall Assessment #RESI-10-02-02, dated April 2013.

On March 28, 2014, RN #117 stated to Inspector #556 that she did not know why a post-fall assessment was not conducted after the Resident #268 had back to back falls and an injury on March 25 and 26, or when Resident #165 fell and sustained a fracture. RN #117 later informed the home's DOC that she had not completed the post-fall assessments as she had not had time to do them. This information was later confirmed by the DOC to Inspector #556 on March 28, 2014.

Nursing staff did not complete post- fall assessments with a clinically appropriate assessment instrument that is specifically designed for falls when Resident #268 had

back to back falls and an injury in March 2014, and when Resident #165 fell and sustained a fracture in March 2014. [s. 49. (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 when a resident has fallen, and the resident is assessed and that where the condition or circumstances of the resident require, such as frequent falls and fall related injuries, a post fall assessment is to be completed, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8 , s. 79 (3) (c and g) in that the following information was not posted as per legislative requirements c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and g)notification of the home's policy to minimize the restraining of residents.

On March 24, 25, 26 and 27, 2014, it was noted by Inspectors #117 and #573, that the home's policy to promote zero tolerance of abuse and neglect of residents and the home's policy to minimize restraints were not posted in the home.

On March 27, 2014, the home's Administrator and DOC stated to Inspector #117 that they were not aware that the policies needed to be posted and that they had never ensured that these policies be posted within the home.

Following a discussion with Inspector #117 on March 27, 2014, the home's Administrator took action and ensured that the home's policy to promote zero tolerance of abuse and neglect of residents and the policy to minimize the restraining of residents were posted in the home's front entrance. [s. 79. (3) (c)]

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 home's policy on to promote zero tolerance of abuse and neglect of residents as well as the home's policy on minimizing restraints be posted in the home, in a conspicuous and easily accessible location that complies with the requirements established by the regulations, to be implemented voluntarily.

WN #8: 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:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 229 (10) 1, in that each resident admitted to the home was not screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The home's DOC and ADOC #S102 stated to Inspector #117 on March 31, 2014, that it is the home's practice to use the 2 Step Tuberculin Skin Test for their Tuberculosis screening program. The test results are to be documented in the residents health care records. They also stated that if the resident has already been screened 90 days prior to admission, this historical information is to be documented in the residents health care record.

A review of newly admitted residents' health care record shows that the home did not screen for tuberculosis within 14 days of admission to the home.

Resident #4, admitted on a specified day in July 2013, has no information in his/her health care record related to being screened for tuberculosis within 14 days of admission or having any information related to being screened 90 days prior to his/her admission.

Resident #5, admitted on a specified day in November 2013, has no information in his/her health care record related to being screened for tuberculosis within 14 days of admission or having any information related to being screened 90 days prior to his/her admission.

Resident #6, admitted on a specified day in July 2013, has no information in his/her health care record related to being screened for tuberculosis within 14 days of admission or having any information related to being screened 90 days prior to his/her admission.

Resident #7 was admitted to the home on a specified day in August 2013. The resident's health care record documents that the resident was not screened for tuberculosis until a specified day in November 2013, 3 months after being admitted to the home.

Resident #325 was admitted to the home on specified day in April 2103. The resident's health care record documents that on a specified day in May 2013, 6 weeks after being admitted, the resident refused to be screened for tuberculosis with the 2 Step Mantoux test. Resident #325's health care record did not indicate that any follow up action was taken by the home to ensure tuberculosis screening. This information was confirmed with RN #S119. On March 31, 2014, the DOC and ADOC #S102 stated to Inspector #117, that if residents refuse to be screened via the 2 Step Mantoux test, the resident's attending physician needs to be notified and a chest x-ray is to be done to ensure tuberculosis screening. No follow up actions related to notifying the physician as to next steps for Resident #325's tuberculosis screening was found in the resident's health care record. [s. 229. (10) 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 each resident admitted to the home is screened for tuberculosis within 14 days of admission, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 53. (4) (a) in that the behavioural triggers were not identified for resident #288 who was demonstrating responsive behaviours.

During Stage 1 of the Resident Quality Inspection, Resident #288 was triggered for further inspection as he/she was noted as having experienced an increase in the number of responsive behaviours related to physical abuse.

Resident #288 is identified has having cognitive impairments. A review of the resident's chart was done by Inspector #556 with the ADOC #S101. No indication physical abuse had been triggered prior to March 2014. The ADOC #S101 stated that since March 2014, the documentation reflects that the resident has been exhibiting the behaviour of being physically abusive four to six times a week and the Point of Care (POC) documentation indicated that the behaviour had been present 17 out of the previous 30 days.

POC documentation indicates that Resident #288's aggressive behaviours related to physical abuse were always documented by the PSW's working on the evening shift.

A PSW working the day shift, stated to Inspector #556 that during the day, Resident #288 was occasionally resistive to care but not physically abusive.

In an interview, on March 27, 2014, RN #S117 stated to Inspector #556 that when a new or escalated behaviour is exhibited then the registered staff looks into why the behaviour is being exhibited and completes the responsive behaviour debrief tool in Point Click Care that helps to identify the behavioural triggers. Staff member #S117 further stated that the behaviour portion of Resident #288's care plan is not up to date and needs to be reviewed.

In an interview on March 27, 2014, ADOC #S101 stated to Inspector #556 that Resident #288's care plan has not been updated to reflect the behaviour of physical abuse and registered nursing staff did not assess Resident #288 for possible behavioural triggers.

The home did not ensure that Resident #288, who is demonstrating new behaviours, specifically physical abuse on evenings, was not reassessed by registered staff and behavioural triggers were not identified for these new responsive behaviours. [s. 53. (4) (a)]

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

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 90 (2) (b) in that procedures are developed and implemented to ensure all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

On March 27, 2014, Resident #325's resident-staff communication response system (the system) console, located in the resident bathroom, was observed by Inspector #573 to be partially affixed to the wall as one screw was missing and the other was partially screwed out of the wall. The system was noted to be functional at that time. On March 31, 2014, Inspector #117 observed that the system console was still partially affixed to the resident bathroom wall. A review of the resident care unit's maintenance log between the dates of March 15 and 31 did not identify any issues or need for repair with the system console in Resident #325's bathroom.

On March 31, 2014, PSW #S130 stated to Inspector #117, that any maintenance issues identified with resident-staff communication response system are to be reported immediately to the registered nursing staff who would notify maintenance for immediate repair. This information was confirmed with unit RN #S134 on March 31. Both PSW #S130 and RN #S134 were shown the partially affixed system console in Resident #325's bathroom. They indicated that maintenance would be notified for repair.

On April 1, 2014, it was observed that Resident #325's bathroom system console was not repaired. Inspector #117 spoke with the maintenance staff #S126 regarding the partially affixed system console. The maintenance staff verified his maintenance logs and informed Inspector #117 that maintenance had not been contacted regarding the system console. Following a discussion with Inspector #117 on April 1, 2014, Resident#325's system console was repaired by the maintenance staff #S126.

Unit nursing staff failed to notify the home's maintenance department to ensure that Resident #325's bathroom resident-staff communication response system console be repaired so as to be in good repair. [s. 90. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 130 (2) in that all areas where drugs are stored are restricted to person who may dispense, prescribe or administer drugs in the home, and the Administrator.

On March 27, 2014, a review of the home's medication storage areas and the security of drug supplies was conducted by Inspector #117. During the review, ADOC #S102 stated to Inspector #117 that the home's nursing ward clerk and the Support Services Manager both have keys to access the locked government stock medication cupboard located in home's basement supply room. This was information was confirmed with the Administrator, DOC and the Support Services Manager. Neither the nursing ward clerk or the Support Services Manager are allowed to dispense, prescribe or administer drugs in the home, and therefore should not have access to secured medication storage cupboards.

The home took immediate action and changed the lock on the government stock medication cupboard. The Administrator and DOC then ensured that only registered nursing staff have access to this locked medication supply cupboard. [s. 130. 2.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 2nd day of May, 2014

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

Lyne Duchesne RN #117.

ANDY. NATARAJAN PT #573

Wendy Patterson RN #556.

RENA BOWEN RN # 549