Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 24, 2015	2015_382596_0014	028449-15	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE GIBSON LONG TERM CARE CENTRE
1925 STEELES AVENUE EAST NORTH YORK ON M2H 2H3

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

THERESA BERDOE-YOUNG (596), JOELLE TAILLEFER (211), NICOLE RANGER (189)

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): October 19, 20, 22, 23, 26, 27, 28, 29, 30 and November 2, 2015.

The following inspections were conducted concurrently with the resident quality inspection (RQI): complaint inspection #35-14, critical incident inspections #645-15, #1765-15, and follow up inspection #13650-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Services (DRS), Assistant Director of Care (ADOC), Business Manager (BM), Food Service Manager (FSM), Program and Support Services Manager (PSSM), Environmental Manager (EM), Family Service Manager (FM), Registered Dietitian (RD), Toronto Public Health Tuberculosis Prevention, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), staffing coordinator,housekeeping aide, dietary aide, maintenance staff, Family Council president, interim Residents' Council president, private caregiver, residents and families.

During the course of the inspection, the inspectors conducted a tour of the home, conducted a dining observation, medication administration observation, observed resident and staff interactions, reviewed clinical health records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (10)	CO #001	2015_378116_0001	596

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The written plan of care for an identified resident under the toileting section indicates to provide extensive assistance by one staff, resident is able to call for assistance with voiding at night.

During an interview with personal support worker (PSW) #107, the PSW reported that on a specified date in October 2015, he/she found the resident's bed linen, soaker pad, and incontinent brief to be heavily soiled. Interview with the identified resident revealed that during the evening of a specified date in October, 2015, he/she was provided an incontinent brief to wear and during the night he/she called for assistance to use the toilet, and did not receive any assistance. PSW #144 who worked on the night shift of a specified date in October 2015, reported to the inspector that during the night, he/she emptied the resident's urine container but did not check if the resident required assistance with toileting.

Interview with registered staff #106 and PSW # 107 confirmed that the resident did not receive the care as specifed in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Record review of an identified resident's progress notes revealed that on a specified date in January, 2015, the resident exhibited responsive behaviour towards staff. The home's Behaviour tracking tool was initiated and PSWs were expected to document the resident's responsive behaviours every 30 minutes on day and evening shifts and every hour on the night shifts.
Record review of the identified resident's Behaviour tracking tool dated three specified consecutive dates in January 2015, revealed there was no documentation completed on the evening shifts, and no documentation completed on the day shifts on one specified date in January, and one in February 2015.

Interviews with PSWs #142, #143 and the Director of Resident Services (DRS) confirmed that documentation was not completed to track the resident's behaviours on the above mentioned specified dates. [s. 6. (9) 1.]

3. Review of the written plan of care dated December 29, 2014, indicated to monitor an identified resident's behaviours every thirty minutes. The above intervention was created since July 2014. Review of the progress notes indicated there were altercations between the identified resident and a co-resident on a specified date in November 2014 and one in January 2015.
Review of the identified resident's progress notes in November 2014, indicated that the resident attempted to take the co-resident's ambulation device, and hit him/her on the head. The progress notes indicated that the co-resident did not sustain any injury as a result of the altercation.

Review of the identified resident's progress notes and a critical incident report indicated that on a specified date in January 2015, the resident removed the co-resident's hand from the hallway rail and pushed him/her sideways. The co-resident sustained an injury and fractures.
Review of the home's Behavior tracking tool indicated that the identified resident's behaviours were not consistently documented every thirty minutes for a two and a half month period, from November 2014 to January 2015, as indicated in the resident's plan of care.

Review of the home's Behaviour tracking tool and interview with PSW# 132 revealed the resident's behaviours were not documented every thirty minutes on five specified dates in January 2015.
Review of the home's Behaviour tracking tool and interview with PSW #147 revealed the resident's behaviours were not documented every thirty minutes on two specified dates in January 2015.

Interview with Assistant Dirctor of Care (ADOC) #111 and DRS confirmed that the provision of care was not documented every thirty minutes as indicated in the resident's plan of care. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan, and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During the dining observation of lunch service in a specified home area on a specified date in October 2015, the inspector observed resident #025's wheelchair tilted backward at approximately 45 degrees, and the resident was being served nectar thick fluid with an adaptive aid by RPN #104.

Review of resident #025's written plan of care dated July 23, 2015, indicates that resident requires assistance with eating and use of adaptive aids at all meals. Review of the meal service report for resident #025 indicates to use an adaptive aid to serve all fluids. The plan of care does not direct staff to tilt the resident's wheelchair backward during meal times.

Interview with registered practical nurse (RPN) #104, registered nurse (RN) #105, registered dietitian (RD), and DRS revealed that the resident should have been sitting upright in the wheelchair while being fed during meals. [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, the following elements: Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled Pharmacy Equipment, Supplies and Medication Carts, policy# LTC-CA-WQ-200-06-17, Revision November 2014, directs the registered staff that drugs with specific storage requirements will be stored in accordance with those requirements. A drug that requires refrigeration shall be kept in the refrigerator located in the locked medication room.

On October 29, 2015, during a medication observation, the inspector observed on an identified medication cart a prescribed medication for an identified resident with a label "keep in the refrigerator". The inspector reviewed the physician order which identified the prescribed medication to be given daily at 8:00 a.m.

During an interview with registered staff #135, the registered staff reported that at the start of his/her shift at 7:00 a.m., he/she found the medication bottle inside the medication cart and is unsure how long the bottle had been there. The registered staff reported that he/she did not administer the medication stored in the cart, instead used a new medication bottle that was kept in the fridge. Interviews with the DRS, ADOC and registered staff #135 confirmed that the medication bottle should not be kept in the medication cart, and was not kept in the fridge in accordance with its requirements. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors that residents do not have access to must be kept closed and locked.

During the initial tour of the home on October 19, 2015, the inspector observed the utility room door on the east side unit on the fourth floor to be open and unlocked. Inspector closed the door and was able to re-open the door; inspector found that the locking mechanism was not working. Inspector spoke with registered staff #101 who reported he/she will inform maintenance staff.

The inspector observed the utility room door on the east side unit on the second floor to be open and unlocked. Inspector closed the door and was able to re-open the door; inspector found that the locking mechanism was not working. Inspector spoke with PSW #137 who reported that the door had been like that for a while and was unsure that the maintenance staff was aware that it required repairing.

On October 29, 2015, the inspector observed the utility room door on the east side unit on the fourth floor to be unlocked, however when the inspector closed the door, the door was not able to be reopened.
The inspector observed the utility room door on the east side on the second floor to be unlocked, the inspector closed the door and re-opened the door. The inspector found that the
locking mechanism was still not repaired. The inspector reviewed the maintenance request log on the second floor and did not see any entries related to the unlocked utility room door.

Interview with PSW #137, maintenance staff #136 and Environmental Manager (EM) #149 confirmed
that the process for reporting maintenance issues is that the nursing staff will document in the maintenance log, and the maintenance staff will review and repair accordingly. Maintenance staff #136 reported that he was unaware of the unlocked utility room door on the second floor and will repair the door immediately. [s. 9. (1)]

WN #5: 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 home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Review of resident #023's written plan of care dated July 2015, indicated to clip the call bell to the resident's sheet when he/she is in bed.

On October 20 and 22, 2015, the inspector observed resident #023 sitting in the wheelchair beside his/her bed. The resident's call bell was attached and tangled within the bed sheets at the foot of the bed.

Interview with the resident revealed he/she can't reach the call bell.

Interviews with PSW #100, #102, #103 and RN #101 revealed the resident could not reach the call bell and it should be attached and placed close to the resident.

Interview with the DRS confirmed that the resident's call bell should be easily seen and accessible to be used by the resident at all times. [s. 17. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written record relating to the home's responsive behaviour program evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review of the home's written responsive behaviours program evaluation and interview with the DRS revealed that it did not specify a date that the evaluation was completed, nor the dates that the changes specified were implemented. [s. 53. (3) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is created and maintained for each resident of the home.

Review of an identified resident's progress notes indicated the resident was exhibiting responsive behaviours since admission to the home. Review of the resident's written plan of care dated July 2014, indicated to monitor the resident's behaviours every thirty minutes.

Review of the identified resident's Behaviour tracking tool and interview with the DRS confirmed that the written records for an identified time period in November 2014 and between February and March 2015, were not found in the home. [s. 231. (a)]

Issued on this 10th day of December, 2015

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

Original report signed by the inspector.