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
Dec 29, 2014	2014_159178_0029	T-028-14	Resident Quality Inspection

Licensee/Titulaire de permis

FAIRVIEW NURSING HOME LIMITED
14 CROSS STREET TORONTO ON M6J 1S8

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

FAIRVIEW NURSING HOME
14 CROSS STREET TORONTO ON M6J 1S8

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

SUSAN LUI (178), NITAL SHETH (500), 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): November 13, 14, 17, 18, 20, 21, 24, 25, 2014.

The following critical incident intake was inspected during this RQI: T-814-14.
The following complaint intake was inspected during this RQI: T-702-14.
The following follow up intakes were inspected during this RQI: T-180-14 and T-181 -14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of nursing (DON), environmental services manager, associate director of nursing (ADON), registered dietitian (RD), resident care coordinator, registered nursing staff, personal support workers (PSWs), cooks, housekeeping aides, laundry aide, residents, residents' family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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
Safe and Secure Home
Skin and Wound Care

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

17 WN(s)
6 VPC(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2013_159178_0026	178

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control (IPAC) program.

Observations, staff interviews and record review confirmed that not all staff follow precautions to prevent the spread of infectious disease within the home.

Review of the clinical records and interview with registered nursing staff confirmed that within the home there are 15 residents who are colonized in the urinary tract with an antibiotic resistant organism, Extended Spectrum Beta Lactamase (ESBL). 11 of the 15 residents were first identified to be positive for ESBL in 2014. Observations confirmed that on each of the affected residents' doors there is a "stop" sign instructing the reader to speak to the nurse for additional instructions.
Interview with registered staff working on two units, revealed that when a staff member comes to them for guidance regarding the "stop" sign on the resident's door, the nurses instruct the staff member only to clean their hands before entering and exiting the affected resident's room.
Interview with the home's infection prevention and control (IPAC) program leader indicated that these residents are on additional precautions, specifically contact precautions, which means that whenever staff provides direct care to the affected residents, they are to wear gloves and a gown.
Review of the home's policy #IFC F-25, titled Management of ESBL, confirms that gloves and disposable gown are to be worn when direct care is provided to residents colonized with ESBL.

Interview with several identified PSWs confirmed they are not wearing gowns when providing direct care, such as changing the brief and providing perineal care to residents colonized with ESBL.

Interviews with the environmental services supervisor and the IPAC leader indicated that the high touch surfaces in the rooms of residents on contact precautions, including those colonized with ESBL, must be wiped with the disinfectant Virox daily after the regular cleaning procedures.
Interview with an identified environmental staff member confirmed that he/she is not wiping high touch surfaces with Virox in the rooms identified as requiring "contact precautions". When interviewed, the staff member confirmed that he/she did not have Virox disinfectant available on the cleaning cart. [s. 229. (4)]

2. Observations within the home and staff interviews confirm that not all staff participate in the implementation of the infection prevention and control program, specifically with proper storage of a resident's catheter drainage bag and tubing.

On November 24 and November 25, 2014, the inspector observed that when not in use, the catheter drainage bag for resident # 008 was stored in the resident's bedside table with no covering on the tubing which would plug directly into the resident's catheter. As a result, the tubing opening may be exposed to bacteria within the bedside table, thereby potentially exposing the resident to bacteria which could cause a urinary tract infection. The home's director of nursing confirmed that the catheter bag should be stored with a cap on the tubing, and that the front-line staff had been educated to this fact.

This non-compliance was previously identified in inspection #2013_159178_0026, dated January 9, 2013, with a compliance order issued. [s. 229. (4)]

3. The licensee has failed to ensure that the information that was gathered on every shift about the residents' infections, was reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

Record review indicated that a total of 15 residents within the home are colonized with ESBL. 11 of the 15 residents were identified as being colonized with ESBL in 2014. Interview with the IPAC program leader indicated that he/she did not review the information monthly in order to detect trends, for the purpose of reducing the incidence of infections and outbreaks. [s. 229. (6)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 information that is gathered on every shift about the residents' infections, is reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks, 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).

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).

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #25's plan of care revealed that the resident requires fluids to be nectar thick. The plan of care also states that the resident should receive the following supplements: 60 ml of resource 2.0 three times per day, and one scoop of protein powder twice a day. The plan of care does not specify whether or not the supplements should be thickened.
Interview with two registered nursing staff members confirmed that there is inconsistent

practice in thickening supplements for this resident. Staff interviews confirmed that one staff member thickens the supplements, while the other staff member does not.

Interview with the registered dietitian (RD) confirmed that in this case the staff did not have clear directions regarding thickening supplements for the resident who requires thickened fluids. [s. 6. (1) (c)]

2. Observation conducted on November 13, 2014, at 12.00 p.m., in the second floor dining room revealed that the cucumber served for minced texture was not minced properly. Rather, it was chopped into small pieces.

A review of the recipe binder indicates that there was no recipe for minced and pureed cucumber.

Interview with the cooks confirmed that they don't have a standardized recipe for minced and pureed cucumber.

Interview with the RD confirmed that there should be a standardized recipe for minced and pureed cucumber for cooks to follow clear directions. [s. 6. (1) (c)]

3. The licensee has failed to ensure that resident #3's plan of care for personal hygiene sets out clear directions to staff.
Resident interview, staff interview and record review confirm that resident #3 requires total assistance for oral care. However, review of the resident's written plan of care confirms that the plan of care does not specify what type of oral care should be provided, or the frequency of the oral care. Resident #3's plan of care states that the resident requires total assistance for oral hygiene, and requires extensive assistance to complete personal hygiene and grooming, and lists various functions of personal hygiene, one of which is "mouth care". The resident's plan of care does not contain any information describing how the resident's mouth should be cleaned or how often.

Interview with resident #3 confirmed that the resident's teeth are brushed only once daily in the morning, and that this is done by the staff. Interview with an evening staff member confirmed that the staff member was unaware that the resident has a toothbrush, and stated that he/she cleans the resident's teeth using a lemon and glycerin swab on the evenings when the resident will accept the care. [s. 6. (1) (c)]

4. 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.
Record review, staff interviews and resident and family interviews confirm the following:
Resident # 3 requires the use of a seatbelt while in the wheelchair to prevent the resident from sliding out of the chair, especially when propelling the chair independently.
On November 1, 2014, the resident's personal wheelchair was removed by family for repairs, and staff provided the resident with a wheelchair which does not contain a seatbelt. The resident slid from the chair and landed on his/her knees. The resident was not injured.
The resident remained in bed until the resident's own wheelchair with a seatbelt was returned that evening. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care for resident #3 is documented.
Record review, resident interview and staff interview confirmed that resident #3 requires total assistance from staff for mouth care. The resident states that the assistance is not offered in the evenings. During interviews, the evening staff stated that the resident frequently refuses mouth care in the evening.
Interviews with the home's DON confirms that if the resident was refusing care, the registered staff should be informed and the refusal of care should be documented on the resident's record. Review of the documentation for November 2014 confirms that the staff documented that the resident received assistance with all necessary personal hygiene care as per the resident's plan of care. Review of the resident's record for the past 3 months does not contain any documentation to indicate that the resident frequently refuses mouth care in the evenings.
The lack of documentation of this refusal of care was confirmed by the home's ADON. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the resident is reassessed and the plan of care is reviewed and revised at any time when care set out in the plan has not been effective.

Record review and staff interviews confirm the following:
Resident #2 fell on October 21, 2014, and November 18, 2014. In both incidents, the resident was assessed and dizziness was identified as having been a factor contributing to the fall.
Review of the resident's written plan of care revealed that the resident's plan of care for risk for falls was not revised after the two falls, and does not address the resident's dizziness as a factor causing risk for falls. The written plan of care does not contain any interventions to address the resident's dizziness in order to prevent future falls. [s. 6. (10)

(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:
-there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
-the care set out in the plan of care is provided to the resident as specified in the plan,
-the provision of the care set out in the plan of care is documented,
-the resident is reassessed and the plan of care is reviewed and revised at any time when care set out in the plan has not been effective, 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 the policy, Management of ESBL, is complied with.

Review of the policy # IFC F-25, titled Infection Prevention and Control, Management of ESBL, revised on February 19, 2014, states that for the third identified case of ESBL, the following steps should be taken:
1. Notify the Health department to assist in implementing an outbreak investigation. If a third case is found, the likelihood of transmission within the home is high.
2. Screen all residents in the home. Screening staff may also be warranted, especially those who give direct care to the residents.
6. Gowning: Wear a disposable gown for direct care or if the environment is grossly soiled, and for cleaning the room/washroom.

Review of the clinical record indicated there are 15 residents within the home colonized with ESBL, of which 11 cases were identified in 2014.

Interview with the IPAC program leader, the DON and the administrator confirmed that the Public Health department was not notified in 2013 or 2014 to implement an outbreak investigation.

Interview with PSWs and registered nursing staff confirmed that staff do not wear gowns when they provide direct care to residents colonized with ESBL. [s. 8. (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 policy, Management of ESBL, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with food that is safe.

Observation conducted on November 13, 2014, at 12.00 p.m., in the second floor dining room revealed that the cucumber served for minced texture was not minced properly by the kitchen, rather it was chopped into small pieces. The pieces of cucumber were observed to be too large to be considered a minced texture.

Interview with the cooks confirmed that the blender is not preparing minced texture cucumber properly, therefore they chop it instead of blending it.

Interview with RD confirmed that chopped pieces of cucumber can be a risk for the residents who require minced texture, and the cook needs to grind the cucumber for minced texture. [s. 11. (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 residents are provided with food that is safe, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the Table in O. Reg. 79/10, s. 18 are maintained. The Table states that in homes designed prior to 2009, lighting at the bed of each resident when the bed is at the reading position, should be a minimum level of 376.73 lux. The Table also states that at each drug cabinet, the lighting should be a minimum level of 1,076.39 lux.

A review of the light meter readings measured by the environmental service supervisor using a cell phone application in the presence of the inspector indicates that in room #104-2 the light meter reading was 136 lux. Likewise, the light meter reading in the drug cabinet (medication room) on first floor was 560 lux.

Interview with the environmental service supervisor confirmed the following:
-the head light in room #104-2, one bulb was not functional and required replacement, and
-the light meter readings in the drug cabinet (medication room), and in room #104-2 is below the standard. [s. 18.]

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 lighting requirements set out in the Table in O. Reg. 79/10, s. 18 are maintained, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration program includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

A review of resident #25's plan of care revealed that October and November weights were not recorded as observed by the inspector on November 21, 2014.

Interview with the registered nursing staff confirmed that the resident was not weighed in October or November to date because the resident has a pressure ulcer and therefore is refusing to be seated on a wheel chair for weight measurement. The staff was not able to provide any documentation that the resident is refusing to be weighed.

Interview with the RD confirmed that weights are measured in the beginning of each month and recorded in the resident record by the seventh day of the month. The RD confirmed that nursing staff did not notify him/her that the resident was refusing to be weighed. [s. 68. (2) (e) (i)]

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 that the nutrition and hydration program includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #7: 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 resident's 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, is fully respected and promoted.

Observation conducted on November 20, 2014, at 12.00 p.m., in second floor dining room revealed that an identified staff member was feeding resident #44 a pureed textured food, scraping food from around the resident's mouth by using a spoon, and feeding the resident the food that was scraped from around the resident's mouth.

Interview with the RD confirmed that in order to maintain the resident's dignity, the staff should not scrape food from a resident's face using a spoon. [s. 3. (1) 1.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home and its furnishings are kept clean and sanitary.

Observations conducted on November 14, 2014, at 9.55 a.m., in room #106's washroom revealed that the toilet, walls and floor were not clean.

Interview with the family member of resident #42 confirmed that he/she often finds the toilet and sink dirty in his/her family member's room, and cleans them.

Interview with the environmental service supervisor confirmed that the above mentioned furnishings should be cleaned by the housekeeping staff. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observations conducted on November 14, 2014, at 1.55 p.m., in the hallway of the first floor, revealed the following maintenance concerns:
-a broken tile on a wall in between room #103 and a shower room,
-a sharp edge of the broken wall guard on a wall close to room #103,
-a dripping tap in the sink in the washroom of room #106.

Interview with the charge nurse confirmed that the above items need repair and had not been reported to the maintenance department.

Interview with the environmental service supervisor confirmed that above items require repair. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.
Record review and interview with the home's DON confirmed that the results of the home's investigation into resident #3's allegation of abuse were not reported to the Director under the Long Term Care Homes Act (LTCHA). [s. 23. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident # 22 is based on an interdisciplinary assessment of the resident's vision.

Resident record review and interview with registered nursing staff indicated that when resident #22 was admitted to the home from the hospital on September 8, 2009, one of the admission diagnoses was glaucoma. Interview with the resident indicated that the resident used eye glasses for reading but since coming into the home the resident did not have them, and the resident had not been seen by an eye specialist since admission.

Review of the quarterly resident assessment instrument (RAI) for April 19, 2013, and July 12, 2013, indicated that the resident's vision was impaired, and the RAI for December 29, 2013 indicated the resident's vision is moderately impaired, and there were no visual appliances in place for the resident.
Record review and interview with registered nursing staff (RN, RPN, ADON, DON) confirmed that the resident's vision was not assessed by an eye specialist since admission. After interview with staff, a referral to an eye specialist was initiated. [s. 26. (3) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the following:
-a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision maker (SDM), if any, within six weeks of the admission of the resident,
-the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and
-a record is kept of the date, the participants, and the results of the conferences.

Review of the clinical record for resident #2 indicated the resident was admitted to the home on an identified date in August, 2014. Interview with the resident's SDM confirmed that the home has not invited the SDM for a care conference until November 17, 2014. Interview with registered nursing staff indicated when a new resident is admitted a care conference is held with the resident's SDM and documented in the progress notes.

Review of the clinical record and interview with registered nursing staff confirmed until the moment of the inspection no evidence that the care conference has been held with the resident's SDM or documented within six weeks of the admission of the resident. [s. 27. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond to the Residents' Council in writing within 10 days of receiving advice of concerns or recommendations.

A review of minutes of the Residents' Council meeting conducted on October 21, 2014, revealed that residents expressed the following concerns:
"When residents go to sleep (sometimes miss 7 p.m. snack) they won't get anything to eat until 8.30 a.m. the following morning. Pureed snacks at 7 p.m. are not distributed by the staff to the residents who require them, as residents are often asleep. Variation of delivery times of the snacks is occurring on the units, 7.20- 8 p.m."

Interview with the President of the Residents' Council confirmed that the home did not provide written response for the above mentioned concerns within 10 days.

Interview with the administrator confirmed that the home has not provided the written response for the above mentioned concerns raised by the Residents' Council, as these concerns were not brought to his/her attention. [s. 57. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

A review of the spring/fall 2014, week 3, Thursday therapeutic menu revealed that the home needs to serve garden salad for minced and pureed texture.

Observation conducted on November 13, 2014, at 12.00 p.m., in the second floor dining room revealed that the dietary staff provided cucumber for residents who require minced and pureed diets.

Interview with the cooks confirmed that they prepared cucumber for minced and pureed diets as it was provided for regular texture diets on the menu. They stated that they have to prepare many things and due to time constraints they gave cucumber instead of garden salad for minced and pureed textures. [s. 71. (4)]

WN #14: 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. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location, in a manner that complies with the requirements, if any, established by the regulations.

Observation on November 13, 2014, confirmed that inspection report #2013_159178_0002 (dated January 22, 2013) was not found posted within the home.

Interview with DON confirmed that this inspection report was not posted within the home. [s. 79. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home seeks the advice of the Family Council, if any, in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the president of the Family Council confirmed that the home does not ask for the input of the Family Council in developing and carrying out the satisfaction surveys.

Interview with the administrator confirmed that the satisfaction surveys are carried out by the corporate office and the home did not provide the Family Council the opportunity for input in developing and carrying out the surveys. [s. 85. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that immediate action is taken to deal with pests.

Observation conducted on November 14, at 9.55 a.m., and on November 21, 2014, at 11.30 a.m., revealed that there are small flying insects in room #106's washroom.
Interview with an identified housekeeping aide confirmed that he/she has observed flies in the above mentioned washroom.
Interview with the charge nurse confirmed that nursing staff is aware that there are flies in this washroom, and that they did not notify the maintenance department about it.

Interview with the environmental service supervisor confirmed that the home has fly trappers placed in the kitchen and in the dining room area, however there is no action being taken to address the issue of the flies in resident's washroom. [s. 88. (2)]

WN #17: 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.
On November 18, 2014, the inspector observed in the narcotic box of the medication cart on 1st floor, the following non-drug related items:
a plastic bag containing several envelopes, labeled with resident's names and labeled as containing "jewelery", various sums of money, "Epen ink", and "identification". The drawer also contained a Blackberry cell phone, a package of batteries, 2 envelopes labeled as containing money, and a wrist watch.

The 1st floor registered staff member and the home's DON confirmed that these items should not be stored in the narcotic drawer. [s. 129. (1) (a)]

Issued on this 2nd day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178), NITAL SHETH (500), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2014_159178_0029
Log No. / Registre no:	T-028-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 29, 2014
Licensee / Titulaire de permis :	FAIRVIEW NURSING HOME LIMITED 14 CROSS STREET, TORONTO, ON, M6J-1S8
LTC Home / Foyer de SLD :	FAIRVIEW NURSING HOME 14 CROSS STREET, TORONTO, ON, M6J-1S8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Natalie Molin

To FAIRVIEW NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_159178_0026, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff participate in the implementation of the infection prevention and control program in regards to:
1) storage of resident # 008's catheter drainage bag
2) following the Provincial Infectious Diseases Advisory Committee (PIDAC)'s guidelines regarding the use of contact precautions for residents colonized with antibioitic resistant organisims (AROs).

The plan shall be submitted via email to susan.lui@ontario.ca by January 15, 2014.

Grounds / Motifs :

1. Observations, staff interviews and record review confirm that not all staff follow precautions to prevent the spread of infectious disease within the home.

Review of the clinical records and interview with registered nursing staff confirmed that within the home there are 15 residents who are colonized in the urinary tract with an antibiotic resistant organism, Extended Spectrum Beta Lactamase (ESBL). 11 of the 15 residents were first identified to be positive for ESBL in 2014. Observations confirmed that on each of the affected residents' doors there is a "stop" sign instructing the reader to speak to the nurse for additional instructions.
Interview with registered staff working on two units, revealed that when a staff member comes to them for guidance regarding the "stop" sign on the resident's door, the nurses instruct the staff member only to clean their hands before entering and exiting the affected resident's room.

Interview with the home's infection prevention and control (IPAC) program leader indicated that these residents are on additional precautions, specifically contact precautions, which means that whenever staff provides direct care to the affected residents, they are to wear gloves and a gown.
Review of the home's policy #IFC F-25, titled Management of ESBL, confirms that gloves and disposable gown are to be worn when direct care is provided to residents colonized with ESBL.

Interview with several identified PSWs confirmed they are not wearing gowns when providing direct care, such as changing the brief and providing perineal care to residents colonized with ESBL.

Interviews with the environmental services supervisor and the IPAC leader indicated that the high touch surfaces in the rooms of residents on contact precautions, including those colonized with ESBL, must be wiped with the disinfectant Virox daily after the regular cleaning procedures.
Interview with an identified environmental services staff member confirmed that he/she is not wiping high touch surfaces with Virox in the rooms identified as requiring "contact precautions". When interviewed, the staff member confirmed that he/she did not have Virox disinfectant available on the cleaning cart.
(210)

2. Observations within the home and staff interviews confirm that not all staff participate in the implementation of the infection prevention and control program, specifically with proper storage of a resident's catheter drainage bag and tubing.

On November 24 and November 25, 2014, the inspector observed that when not in use, the catheter drainage bag for resident # 008 was stored in the resident's bedside table with no covering on the tubing which would plug directly into the resident's catheter. As a result, the tubing opening may be exposed to bacteria within the bedside table, thereby potentially exposing the resident to bacteria which could cause a urinary tract infection.
The home's director of nursing confirmed that the catheter bag should be stored with a cap on the tubing, and that the front-line staff had been educated to this fact.

This non-compliance was previously identified in inspection #2013_159178_0026, dated January 9, 2013, with a compliance order issued.
(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

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