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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2017	2017_631210_0016	022856-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

SLAVICA VUCKO (210), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 29, October 2, 3, 4, 5, 6, 10, and 11, 2017

The following complaints were concurrently inspected: #024251-15 related to skin and wound care, dining and snack service, menu planning, #029486-16 related to continence care and bowel management.

During the course of the inspection, the inspector(s) spoke with family members, residents, Executive Director, Director of Care, Assistant Director of Care, Director of Food Services, Dietary Aid, Chef, Nutrition Services Manager, Environmental Services Supervisor, registered nursing staff, personal support workers, neighbourhood coordinators.

The inspector observed the provisions of care, medication administration, kitchen and reviewed the resident' clinical record.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Food Quality
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Two complaints were received by MOHLTC on a specific date, that resident #004 developed additional health issues related to staff assistance with activity of daily living (ADL).

A review of resident #004's written plan of care revealed the resident had potential for additional health problems related to impaired mobility, chronic disease, skin problems on different areas of body.

A review of the home's policy Skin and Wound Care program, reviewed August 4, 2017, revealed a complete Skin Assessment will be performed when there is a change in skin integrity and weekly thereafter until it is healed. The current tool to be used was the Skin/Wound Assessment form for non-PCC homes. The registered team member will observe for clinical signs and symptoms of infection, inflammation, swelling, pain, increased temperature, odors, purulent exudates, systemic fever; complete the wound assessment of the areas reported and weekly thereafter.

A review of the progress notes, on an identified date, a registered nurse assessed the specific body area and identified an impaired skin integrity. According to the home's policy Staging of Wounds, dated August 4, 2017, based on Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines, definitions of altered skin integrity was provided.

A review of the home's electronic Wound Rounds system for skin and wound assessment and interview with registered staff #115, #114 and #113 confirmed the impaired skin integrity on the specific body area of resident #004 was not assessed using the home's clinically appropriate assessment tool for skin and wound assessment as required.

The inspection for resident #003 skin and wound care was triggered as an extended sample from a non-compliance found during inspection of a complaint intake.

A review of resident #003's clinical record revealed on a specified date, the registered staff documented in progress notes that the resident had impaired skin integrity. The skin on a specific resident's body area was impaired, dry dressing was applied, the resident to remain in bed, and turning and repositioning was initiated every two hours. On a specified date, the order for dressing was discontinued because the identified area on the specific body area had healed. On another specified date, the registered nurse documented in the progress notes that resident had the same skin problem on the same body area. The physician ordered a treatment and a weekly wound assessment to be done. On a specific date, the evening registered nurse documented a weekly skin assessment that there was an identified area of altered skin integrity. The registered nurse further documented that the appropriate dressing was applied.

A review of the policy Skin and Wound Care program, reviewed August 4, 2017, revealed a complete Skin Assessment will be performed when there is a change in skin integrity and weekly thereafter until it is healed. The current tool to be used was the Skin/Wound Assessment form for non-PCC homes. The registered team member will observe for clinical signs and symptoms of infection, inflammation, swelling, pain, increased temperature, odors, purulent exudates, systemic fever; complete the wound assessment of the areas reported and weekly thereafter.

Interview with DOC staff #113 and registered nurse #115, the leader of the skin and wound care program, revealed the expectation is the skin and wound assessments,

(initial and weekly) to be documented in the Wound Rounds system, Wound Assessment form, in the computer by the registered staff. The Wound Assessment form captures the description of the wound such as the type, stage, dressing, tissue type, measurements, exudate, peri-wound criteria, wound edge, pain, odor, signs of infection, if the patient is on antibiotics and the outcome.

A review of the Wound Rounds system and interview with staff #113, #114 and #115 confirmed that when resident #003 had impaired skin integrity on specified dates and skin and wound assessments were not performed and documented in the Wound Round system using the home's clinically appropriate assessment tool for skin and wound assessment. [s. 50. (2) (b) (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 to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

This inspection was triggered as an extended sample from a non-compliance identified during inspection of a complaint intake related to impaired skin integrity.

A review of the home's policy Staging of Wounds, dated August 4, 2017, based on Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines, specific definitions of altered skin integrity was provided.

A review of resident #003's progress notes revealed on a specified date, the resident had impaired skin integrity and identified treatment was applied. On the same day the physician ordered a treatment for the altered skin integrity on the specific body area. The impaired skin integrity persisted until a specified date.

A review of the clinical record and interview with aDOC staff # 114 and DOC revealed that the resident's altered skin integrity was not documented and assessed appropriately and therefore, the resident's skin area was treated incorrectly. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Complaints were received by MOHLTC on specified dates, that there was an ongoing issue with identified care needs of resident #004, he/she was waiting long time to be assisted with ADLs and he/she developed skin problems because of using the incontinent product.

A review of resident #004's clinical record revealed that during the 14 day observation until a specified date, the resident required assisstance and had identified problems with toileting. A review of the quarterly minimum data set (MDS) assessments revealed the resident's continence status changed since a specified date because his/her health status changed, he/she has impaired mobility and he/she required assistance with toileting from two people using the mechanical lift. Prior to this date the resident was continent and was able to use the washroom independently.

Interview with ADOC staff #114 revealed when there is a health and continence status change of a resident it should be an assessment done using the RAI MDS tool and the voiding and bowel elimination record. Interview with DOC staff #113 revealed the on-line tool Continence Evaluation assessment form should be used as a comprehensive tool for continence assessment.

A review of the Continence Care policy, reviewed August 2017, revealed each resident who is incontinent will have a continence assessment using a RAI MDS tool in combination with a resident specific assessment, using the on-line assessment, named Continence. A review of the on-line Continence Evaluation assessment tool revealed a content of different sections for continence assessment such as continence history, symptoms of stress, urge, overflow incontinence and product use. [s. 51. (2) (a)]

2. Resident #011's clinical record was reviewed as an extended sample for continence assessment, due to a non-compliance identified in the continence management program. Resident #011's clinical record revealed that during 14 day observation on a specified date, the resident had deteriorated type of incontinence. A review of the admission MDS

assessment from a specified date, revealed the resident was incontinent. The Continence Evaluation Assessment tool was not located in the clinical record. [s. 51. (2) (a)]

3. Resident #010's clinical record was reviewed as an extended sample for continence assessment due to a non-compliance identified in the continence management program. Resident #010's clinical record revealed that during the 14 day observation until a specified date, the resident had deteriorated type of incontinence. A review of the quarterly minimum data set (MDS) assessments revealed the resident was continent during the last year but his/her continence status deteriorated. The Continence Evaluation Assessment tool was not located in the clinical record.

Review of the continence assessment record for residents #003, #010, and #011 and interview with DOC confirmed the residents who were incontinent did not receive a continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, on the Continence Evaluation assessment form as per the home's policy. [s. 51. (2) (a)]

4. The licensee has failed to ensure that the resident who is incontinent have an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

A complaint was received by MOHLTC on a specified date, that there was an ongoing issue with toileting of resident #004, he/she waited long time to be assisted with ADL and he/she developed skin problems because he/she could not wait long once he/she required assistance with ADL and used the incontinent product.

A review of resident #004's written plan of care revealed the resident is incontinent. He/she uses incontinent products daily.

Interview with resident #004 revealed he/she is able to communicate when she required assistance with ADL and his/her preference was to be toileted. He/she frequently spends time on a different floor. When he/she needs to go to washroom he/she will transport him/herself to the unit and he/she will tell staff to assist him/her with toileting. If there is no one in the hallway he/she will go into the room and call the call bell for assistance. After he/she is assisted with the toileting he/she will go again to the activity room. Resident indicated he/she would forget sometimes to ask staff for toileting, and they don't come to the other floor to remind him/her. Interview with PSW #117 revealed resident

#004 is being assisted with toileting in the morning and lunch if he/she comes on the unit. Staff does not go to the other floor to remind him/her about toileting, but they are waiting for the resident to come on the unit to ask for assistance.

A review of resident #004's written plan of care for continence management, interview with resident #004's family member, the resident and PSW #117, #116 and #113 indicated the present care plan did not reflect the current continent status and the preference of the resident to be toileted, and the resident was not on a scheduled toileting routine to promote continence once he/she became occasionally incontinent. [s. 51. (2) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

The complaint was received by MOHLTC on a specified date, in regards to poor quality and taste of the food in the home.

Observation on October 6, 2017, at 1100 hours revealed that Chef #111 was preparing beef cheese burger. The inspector asked him/her to provide the recipe for the burger. The Chef found the recipe in the binder, in which all recipes were listed alphabetically.

Upon asking the Chef how the burgers were prepared, he/she indicated that the patties were cooked, and other ingredients were to be provided separately including cheese slice to dietary aides to serve to residents. The Chef demonstrated unawareness about the recipes for minced and pureed food items listed alphabetically in the recipe binder when asked.

A review of the provided recipe of beef cheese burger revealed that cheese slice should be placed on each burger and heat only until cheese is melted. The recipe binder did not include a recipe for pureed beef cheese burger.

Interview with Chef #111 revealed that the cheese was not melted for the burger as in accordance to the recipe because residents do not like the cheese heated on their burgers and that is why the recipe had not been followed. The Chef indicated that the previous Director of Food Service was aware that residents did not like heated cheese on their burger but had not revised the recipe. Chef #111 was not able to provide a recipe for pureed beef cheese burger from the recipe binder to the inspector and he/she was not aware if there was one. Chef #111 indicated that the home do not have recipes for minced and pureed items, and they prepare minced and pureed from regular food item, and he/she always taste the food before serving to ensure it taste good.

A review of the home's policy #06-01, entitled "Food Production", dated April 7, 2017, indicated that standardized recipes be used in the food service department in the home for consistent results and quality of the finished product.

Interview with Director of Food Service and Administrator revealed that there should be a standardized recipe for each item and staff should follow it, otherwise it can affect the taste, nutritive value, appearance and quality of the food. [s. 72. (3) (a)]

2. The licensee has failed to ensure that the staff of the home comply with a cleaning schedule for all the kitchen equipment.

On a specified date, the inspector observed stains and grease on the stove, the knobs of the stove/ oven, oven had brownish black stains and grease, and the bottom area of the dish machine had dirt and stains. The floor underneath the dish-washing area was dirty and required cleaning.

A review of the documents posted in the kitchen binder entitled "Cleaning Tasks 8-4 Mon & Thus Shift" indicated to initial and date as tasks are completed. A review of these forms

revealed that during four months the forms were not signed off by staff.

A review of the document entitled “Cleaning Schedule for Person in Charge Of Delivery (Mondays and Thursdays)” revealed that staff signed for only one day on a specific date, that steam carts for one of the home areas were cleaned.

Interview with Chef #111 revealed that the home has a shift scheduled for cleaning, however that person was sick and did not come to work. Chef #111 confirmed that they do not use the oven, and the above mentioned areas required cleaning.

A review of the home’s policy #Tab 09-17, entitled “Cleaning Schedules”, dated May 1, 2017, indicated to assure the proper cleaning and sanitizing of utensils and equipment, food services team members must follow a cleaning schedule. The director of food service will routinely check the cleanliness of the completed cleaning duties.

Interview with the Director of Food Service witnessed the above mentioned areas and confirmed the requirement of cleaning. He/she confirmed the above mentioned forms were not signed by staff, and staff should have complied with the cleaning schedule. [s. 72. (7) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 120. Responsibilities of pharmacy service provider
Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
2. Evaluation of therapeutic outcomes of drugs for residents.
3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
5. Educational support to the staff of the home in relation to drugs.
6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.

Findings/Faits saillants :

1. The licensee has failed to ensure that the pharmacy service provider participates in risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.

A review of the Medication Incident Report forms for the first quarter of 2017 revealed an incident on a specified date. A registered staff discovered that there were two orders for a specific medication with two different dosages and the previous one was not discontinued. On the second page of the medication incident form there is a section to be completed by the Pharmacy Operations Manager and corrective action to prevent re-occurrence.

A review of the Medication Incidents Policy, dated January 17, 2017, revealed the medication incident reports will be analyzed by nursing administration, the Pharmacy Manager, and/or the consultant pharmacist to determine whether pharmacy and/or nursing procedures require modification. The Pharmacy and Therapeutic Committee will also review a summary of all Medication Incident Reports at scheduled Nursing home meetings to determine if corrective actions are necessary to prevent future harm.

According to Professional Advisory Committee meeting minutes from February 28, 2017, and June 6, 2017, the pharmacist reviewed the 2017 reports. Interview with DOC was not able to confirm that Pharmacy was notified about the incident on January 5, 2017, and corrective action was taken to prevent re-occurence. [s. 120. 3.]

Issued on this 22nd day of November, 2017

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

Original report signed by the inspector.