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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2017	2017_671684_0004	019082-17	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

EATONVILLE CARE CENTRE
420 THE EAST MALL ETOBICOKE ON M9B 3Z9

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

SHELLEY MURPHY (684), CHAD CAMPS (609), LOVIRIZA CALUZA (687), NATASHA MILLETTE (686)

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 18-22 and 25-29, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Social Worker (SW), Dietary Manager (DM), Dietary Supervisor (DS), Programs Manager (PM), Physiotherapist (PT), Public Health Officer, Registered Nurses (RNs), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Dietary Aides (DA), Housekeeper, residents and family members.

The inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, internal investigations, policies, procedures, programs, and program evaluation records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

12 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an assessment of the resident and the resident's need and preferences.

During an observation of resident #014's room, Inspector #687 noted the use of a transfer device.

Inspector #687 conducted an interview with resident #014. Resident indicated they preferred to use a transfer device.

A review of resident #014's current plan of care, found no documented evidence for the use of a transfer device. A further review of resident #014's health care records found no evidence of an assessment of the resident's needs related to the use of the transfer device.

Interviews with PSW #131 and RPN #132 by Inspector #687, indicated that resident #014 used a transfer device. [s. 6. (2)]

2. The licensee has failed to ensure that the resident, resident's substitute decision-maker(SDM), if any, and any other persons designated by the resident or substitute

decision-maker was given an opportunity to participate fully in development and implementation of the resident's plan of care.

During the course of the inspection resident #001 was identified by their SDM as requiring medication to manage a disease. The SDM informed inspector #684 of a concern regarding not being informed of a change to resident #001's medication order.

A review of the health care records for resident #001 indicated a change to the resident's medication order on a specified date. A further review of the health care records, found no indication that the substitute decision-maker and/or the resident were made aware of the change in medication.

A review of the home's policy entitled "Assessment/Documentation Plan of Care and Care Plan- RCS C-15" last revised March 31, 2017, indicated that registered staff/delegate would ensure that the resident, resident's SDM if any, or any other person designated by the resident or SDM were given an explanation regarding changes or updates to the plan of care.

During an interview with RN #101, they indicated that the process for notifying substitute decision makers (SDM) when a medication was changed was to contact the family/SDM and to sign off on the physician order once they have contacted the family/SDM about the medication change.

During an interview with the DOC, they indicated that staff were expected to notify family of all changes to medications and to document the communication by making a notation in the progress notes and on the physician order sheets. The DOC acknowledged that resident #001 and their SDM were not given an opportunity to participate fully in the development and implementation of the resident's plan of care in relation to changes in medication. [s. 6. (5)]

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

During the course of the inspection resident #009 was identified as being involved in an incident, which resulted in a injury.

Inspector #684 reviewed the current plan of care which indicated that resident #009 required safety measures to be in place to prevent further incidents.

The following observations were made during the course of the inspection:
On two separate occasions safety measures where not in place for the resident as per the written plan of care.

Interviews held with PSW #122, RN #136 and Physiotherapist (PT) #138, indicated that resident's #009 had safety interventions which were to be in place to prevent injuries.

During an interview held with ADOC #144, they verified that staff were to use the plan of care to verify interventions for injury prevention. The ADOC, further acknowledged that the care set out in the plan of care for resident #009 was not provided as specified. [s. 6. (7)]

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, to be implemented voluntarily.

WN #2: 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, furnishings and equipment were kept clean and sanitary.

Inspector #686 observed, resident #026's room and identified soiling on the walls, as well as on a light fixture.

Further observations of resident #026's room found soiling on the walls and a light fixture to still be present one week later.

A review of the home's policy titled "Wall Washing- ES C-10-30", last revised January 21, 2015, indicated that wall washing was to be performed yearly and more frequently if required.

During an interview with Housekeeper #109, they verified resident #026's room was cleaned daily and walls were to be spot cleaned as necessary.

During an interview with the Environmental Service Manager (ESM), they verified the inspector's housekeeping observations in resident #026's room. The ESM further indicated that the housekeeper should have spot cleaned the soiled walls during the daily cleaning of the room and that this did not occur. [s. 15. (2) (a)]

2. a) Inspector #687 observed the following: dining rooms at 1350 hours, at 1415 hours, 1430 hours and at 1505 hours all contained serving counters which were heavily soiled on the surrounding glass sneeze guards and the top of the metal covers.

b) Inspector #684 observed the following in one dining room: the glass on the back of the serving counter was observed to have white stain marks and one plate cover was observed to have a white residue on it.

Inspector #686, noted that the sides and bottom of the serving counter on one floor to be unclean with a buildup of residue. A few days later, the serving counter and covers remained soiled with residue. The reservoirs were noted to have food particles floating in the water with a brown film on the bottoms. Clean plates were observed stacked on the bottom shelf of the serving counter which had a residue buildup.

A review of the homes policy on "Cleaning and Sanitization– FNSFS010" last revised June 15, 2016, indicated that all surfaces coming in contact with food would be properly cleaned and sanitized, prior to and after use.

During an interview Dietary Aid (DA) #104 indicated that the serving counters were

cleaned twice a day, once after breakfast and once after lunch.

During an interview after the lunch meal service, with the Dietary Manager (DM) they verified the uncleanliness of the serving counter, that the serving counter should have been cleaned after the lunch meal service and, that this did not occur. [s. 15. (2) (a)]

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

Inspector #684 noted that one of the chairs in a dining room was torn with foam protruding, while Inspector #687 noted at the same time on the fourth floor west dining room, another chair that was torn with exposed foam.

Inspector #687 noted the veneer on the television stands located in four of the home's dining rooms to be cracked and chipped down to the particle board. The television stand on the third floor dining room was in such disrepair that the veneer was bubbling with holes, exposing the particle board underneath.

A review of the home's policy titled "Maintenance Requisitions- ES E-20", last revised January 21, 2017, outlined that the home's equipment and furnishings were to be maintained in good condition. A Physical Plant Service Requisition (PPSR) form was to be completed for all items requiring repair or replacement by the maintenance department.

A review of the home's policy titled "Wood Surfaces- ES C-10-40", last revised January 21, 2017, outlined that all wood surfaces were to be maintained in good condition.

During an interview with Inspector #686, the Environmental Service Manager (EMS) verified the disrepair of the two chairs and the television stands observed in the dining areas. The EMS indicated that the staff should have completed the PPSR form for the torn chairs and television stands and that this did not occur. The EMS then proceeded to remove the two chairs and called maintenance for the television stands. [s. 15. (2) (c)]

4. During a dining observation, Inspector #686 noted that a serving counter had three of the four dials broken off while the plastic guard was broken off, with a sharp edge exposed.

The previous disrepair to the serving counter was noted in addition to a missing bottom

door, rusted metal hinges as well as a corroded water drain. All serving trays observed were chipped and cracked, while the plastic veneer on the coffee cart was scoured and peeling off. A plastic lip plate was scraped and stained and many of the tray service plastic covers were peeling.

A review of the home's policy titled "Maintenance Requisitions- ES E-20", last revised January 21, 2017, outlined that the home's equipment and furnishings were to be maintained in good condition and a PPSR form was to be completed for all items requiring repair or replacement by the maintenance department.

During an interview, with the Dietary Manager (DM), they verified the disrepair noted to the serving counter. The DM verified the disrepair of the plastic cart, trays, plates and tray covers and that the items identified required replacing. [s. 15. (2) (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 the home, its furnishings and equipment are kept clean and sanitary as well as ensure that the home, furnishings and equipment are maintained in a safe condition and in good state of repair, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

Inspector #687 conducted multiple observations during the a meal service in a dining room, on a day in September, 2017. The Inspector noted that there were two residents that were not provided assistance with eating when the meal was placed in front of the residents.

Resident #038 was served their meal and it was noted that they were trying to find their utensils but were unable to locate them. Thirty minutes later, PSW #104 provided the resident some assistance so they could feed them self. Resident #038 was noted to have a few bites of their meal and then left the dining room with no further assistance to complete the meal.

Resident #039 was observed with a meal placed in front of them, but did not receive assistance with their meal and did not make any attempt to feed themselves. The plate was then removed without any further assistance provided and staff did not inquire if the resident wanted any more of the meal.

A interview with RN #105, after the meal service indicated that resident #038 and #039 required assistance with meals. [s. 73. (2) (b)]

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 who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #4: 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 controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

A) During an interview with Inspector #686, RPN #105 indicated that controlled substances requiring refrigeration were kept in a locked box in an unlocked refrigerator, located in the locked medication storage room.

During an interview, RPN #110 verified that several vials of four milligram (mg) per millilitre (mL) of Lorazepam injectable was stored in a single locked box, in a single locked medication storage room.

During an interview with the DOC and ADOC #112, they verified the Lorazepam injectable was stored in a single locked box in a single locked medication storage room, and a review of the regulation was conducted. They acknowledge that the refrigerated Lorazepam was not stored in a separate, double-locked stationary cupboard in the locked medication storage room.

B) A review of the licensee's policy "Narcotic/Controlled Substances", last revised April 9, 2015, indicated that narcotic and controlled substances were to be stored in a separate and double locked drawer.

During an interview with ADOC #112, they indicated that the "Narcotic/Controlled

Substances" policy provided unclear direction, whereby staff were to use two locks to store controlled substances rather than a separate, double locked stationary cupboard in the locked area.

C) During an interview ADOC #112 was asked to provide the licensee's controlled substances storage policy to which they provided the 'Drug Destruction and Disposal" policy.

A review of the licensees policy "Drug Destruction and Disposal", last revised July 15, 2013, indicated that surplus narcotic/controlled substances may be removed from the count and kept together with the surplus narcotic drug record sheet in a double locked cabinet in the medication room or Director of Nursing Office.

The locked utility room in the home's basement was noted to have a single locked cabinet which stored controlled substances for destruction.

During the same interview with ADOC #112, they indicated that controlled substances for destruction were kept in a single locked utility room in a single locked cupboard and verified this practice was not in compliance with the regulation. [s. 129. (1) (b)]

2. The licensee has failed to ensure that 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.

Inspector #684 observed RPN #118 conducting a medication pass for resident #001. The inspector observed the controlled substances box in the bottom of the medication cart to be unlocked.

An interview held with RPN #118, indicated that their practice was to lock the medication cart and leave the controlled substances box unlocked throughout the day, despite their awareness for controlled substances to be double-locked.

Inspector #684 reviewed the licensee's policy titled "Drug Inventory Control" which was last reviewed on January 16, 2017, as well as the licensee's policy titled "Narcotics/Controlled Substances RCS F-30" last revised April 5, 2017, both indicated narcotic and controlled substances were to be stored in a separate and double locked drawer.

In an interview held with the Administrator, they acknowledged that RPN #118's practice was not in keeping with the licensee's policies and that controlled substances were not locked in a separate area within the locked medication cart. [s. 129. (1) (b)]

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 ensure that 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored was kept locked at all times when not in use.

Inspector #684 observed a medication cart in the hallway on a unit, unlocked and unsupervised.

Inspector #684 was able to open the top drawer of the cart which held numerous resident medications such as Trazadone, Tylenol, apo-k, furosemide and sulfatrim. While the cart was unlocked numerous residents and staff were observed to be passing by.

During an interview with RPN #117 they acknowledged that the medication cart was to be locked at all times when unsupervised, and further acknowledged that the lock was not working properly on the medication cart.

Inspector #684 brought concerns forth to the DOC and the Administrator, who verified that the home's requirement was for all medication carts to be kept locked at all times when not in use. [s. 130. 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 all areas where drugs are stored shall be kept locked at all times when not in use, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #684 observed RPN #118 conduct the a medication pass on a unit for resident #001. Upon cross referencing the physician orders with RPN #118 for resident #001, all prescribed medications were available except one medication. RPN#118 was unable to locate the medication.

Inspector #684 reviewed the medication administration record and noted that RPN #118 signed for administering the missing medication for resident #001. RPN #118 verified that they did not administer this medication, and acknowledged that they were aware of the home's medication administration policies.

A review of the home's policy titled "Medication Administration RCS F-05" last revised April 5, 2017, outlined that all medications were to be administered by Registered Staff as per the physician's frequency order and documented in the resident's electronic Medication Administration Record (eMAR).

During an interview held with the Administrator, it was verified that RPN #118 did not administer the missing medication to resident #001 in accordance with the directions for use as specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Inspector #684 observed infection control bags which held Personal Protective Equipment (PPE) hanging on resident room doors with no signage to indicate what the precautions were for, or which PPE was to be used.

Inspector #687 also noted multiple resident rooms with PPE hanging on the doors but no signage to indicate which resident was on isolation, the type of precautions required, nor which PPE to use.

A review of the licensee's policy titled "Additional Precautions- IFC F-05" last revised May 25, 2016, stated "Airborne Precautions" sign on resident's door indicating visitors to report to the Nursing Station. Also place a "Contact Precautions" sign if required.

Review of the "Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions, In All Health Care Settings, third edition" was the document that was developed by the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (PIDAC-IPC). PIDAC-IPC was a multidisciplinary scientific advisory body that provides evidence-based advice to the Ontario Agency for Health Protection and Promotion (Public Health Ontario) regarding multiple aspects of infectious disease identification, prevention and control. PIDAC-IPC's work was guided

by the best available evidence. Additional Precautions should be posted:
A sign that lists the required precautions should be posted at the entrance to the resident's room or bed space; and
Signage should maintain privacy by indicating only the precautions that were required, not information regarding the resident's condition.

Inspector #684 had an interview with ADOC #112 who indicated that the home's process was to identify rooms that required precautions in place and place signage at the door with a stop sign symbol on the front of the room door. The ADOC indicated that the home's signage did not outline the type of precautions required because of concerns over resident privacy.

During another interview held with the ADOC #112 on the same day they verified that the home did not follow PIDAC best practice principles for infectious disease identification, prevention and control in the development of the homes policies and procedures and subsequent implementation. [s. 229. (4)]

2. During the course of the inspection resident #004 was identified as having an illness through an MDS assessment.

Inspector #687 conducted an interview with ADOC #112, who indicated registered staff on each floor enter resident symptoms on the infection surveillance record online.

Inspector #687 conducted an interview with RN #130, who identified any residents with symptoms were to be documented under progress notes including assessments and vital signs. The RN further identified that if a resident's condition was unstable, they would initiate the line listing for symptoms and notify the ADOC.

Inspector #687 interviewed ADOC #112, who indicated that registered staff and PSWs were to be constantly vigilant in assessing residents for signs and symptoms of infection. The ADOC also explained that registered staff were to document in progress notes every shift when a resident was started on treatment and onset of symptoms. They indicated they relied on the Infection Surveillance list submitted by the registered staff.

A review of the Health Records of residents #004, 044, 040 ,041, and 042 and review of the Infection Surveillance list for a unit in the past year indicated multiple residents were on the list for an infection:

During an interview with ADOC #144, they verified there were multiple residents demonstrating symptoms in the past six months and that these symptoms were not indicated on the Infection Surveillance list until the residents were receiving treatment for their symptoms. [s. 229. (4)]

3. The licensee has failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and staff on every shift record symptoms of infection in residents and take immediate action as required.

During the course of the inspection resident #004 was identified as having had a infection through a MDS assessment.

Inspector #687 interviewed ADOCs #112 and #144, who both indicated that registered staff were to be vigilant in monitoring, assessing and documenting symptoms on every shift. The ADOCs also indicated that resident #004 symptoms were not monitored on every shift and they were not notified of the symptoms for many days until the resident was reassessed by the physician. [s. 229. (5) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her Personal Health Information within the meaning of the personal health information protection act, 2004 kept confidential in accordance with the Act.

Inspector #684 observed an electronic medication administration record (eMAR) screen unlocked and visible during medication administration to resident #001. The screen displayed personal health information including the resident's medication administration record. This information was visible to residents, family and visitors that were passing by in the hallway.

During an interview with RPN #118 they verified that they left the eMAR screen unlocked and visible while stepping away from the cart to administer medication to other residents on the unit.

Inspector #684 reviewed the licensee's policy titled "Confidentiality Policy- H-35" last revised February 21, 2017, which outlined that confidential information included: personal health information, meaning identifying information about an individual in oral or recorded form.

During an interview with the DOC, they acknowledged resident #001's right to have their Personal Health Information kept confidential in accordance with the Act and that this did not occur. [s. 3. (1) 11. iv.]

WN #9: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on, at a minimum, interdisciplinary assessment of any identified responsive behaviours.

Inspector #686 observed resident #013 with a change in their skin integrity.

Resident #013 was inquisitive in the change to their skin. Skin integrity issues were noted in the area the resident was interested in.

A review of resident #013's Minimum Data Set (MDS) assessment identified that they exhibited a specific responsive behaviour related to skin integrity.

A review of resident #013's current plan of care did not identify information regarding their responsive behaviour.

During an interview with RN #123, they indicated that resident #013 had a responsive behaviour which at times compromised their skin integrity.

During an interview with RN #148 (the home's skin and wound program lead), they verified that resident #013 exhibited a specified responsive behaviour and that the home used interventions to alleviate such behaviours.

A review of the home's policy titled "Plan of Care and Care Plan- RCS C-15" last revised March 31, 2017, indicated that the plan of care reflected the resident's current condition and risks.

During the same interview with RN #148, they verified that resident #013's behaviour should have been identified in the resident's plan of care and that this did not occur. [s. 26. (3) 5.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk referred to in paragraph.

During the course of the inspection resident #004 was observed with bed rails being used.

Inspector #687 reviewed plan of care which indicated that side rails were in place as a restraint. Physician order indicated side rails were a restraint. Consent noted on chart from SDM signed for use of side rails as a restraint.

Inspector #687 reviewed resident #004's health care records and current plan of care and found no documented evidence that alternative measures were tried prior to the implementation of the use of the bed rail restraint.

A review of the licensee's policy titled Restraints- RCS E-25 last revised May 1, 2014 outlined that if the interventions/treatment was not effective, the care team would review the plan of care and introduce alternative measures to the use of a physical restraint. These are implemented, documented in the care plan, and electronic progress notes, and evaluated to determine effectiveness.

During an interview with RN #130, they confirmed there was no documented evidence of alternative measures tried prior to the implementation of the use of resident #004's bed rail restraint. [s. 31. (2) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure procedures were developed and implemented to address lingering incidents of offensive odours.

During the course of the inspection, Inspector #686, noted resident #011's personal space had an offensive lingering odour.

A couple of days later resident #011's personal space was noted to have the same lingering offensive odour.

A review of the home's policy titled "Quality Management Urine Order Audit- ES C-25-15", revised January 21, 2015, indicated that all lingering odours of the home were to be investigated and eliminated.

During an interview with housekeeper #109, they verified that when a lingering offensive odour was noted they would use a disinfectant to eliminate the odour.

During an interview with the Environmental Service Manager (ESM), they verified the lingering offensive odour in resident #011s personal space. The ESM further indicated that 26 resident personal spaces were previously investigated and found to have lingering offensive odours and acknowledged that resident #011's personal space was not one of the 26 rooms identified as having a lingering offensive odour. [s. 87. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures were maintained and kept free of corrosion.

During the course of the inspection, Inspector #686 observed resident #012's bathroom plumbing fixture to be corroded and scaled. Resident #008's bathroom plumbing fixture and resident #013's bathroom plumbing fixture were noted to be corroded. A few days later the corrosion noted to the plumbing fixtures in the bathrooms of resident #008, #012, and #013 remained.

A review of the home's policy titled "Maintenance Person- ES B-10-40", last revised January 21, 2017, outlined that maintenance staff were to maintain the home, equipment, furnishings, fixtures, and grounds in proper condition.

During an interview the Environmental Service Manager (ESM) verified the corrosion to the plumbing fixtures in the bathrooms of resident #008, #012, and #013 and acknowledged that due to the advanced state of corrosion, the plumbing fixtures had been that way for some time. The ESM indicated that the corrosion should have been identified by housekeeping while performing the monthly deep clean of the residents' bathroom and reported via the Physical Plant Service Requisition form to maintenance staff for repair. [s. 90. (2) (d)]

Issued on this 11th day of October, 2017

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

Original report signed by the inspector.