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

Division de la responsabilisation et de la performance du système de santé
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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
Apr 24, 2015	2015_219211_0004	T-1682-15	Resident Quality Inspection

Licensee/Titulaire de permis

UKRAINIAN HOME FOR THE AGED
767 Royal York Rd. TORONTO ON M8Y 2T3

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

IVAN FRANKO HOME
767 Royal York Road TORONTO ON M8Y 2T3

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

JOELLE TAILLEFER (211), NITAL SHETH (500), SHIHANA RUMZI (604)

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): February 6, 9, 10, 11, 12 and 13, 2015.

The following inspections were completed during this RQI: Complaint T-3094-14, Critical incident report T-1132-15.

During the course of the inspection, the inspector(s) spoke with the administrator, assistant administrator (AA), director of care (DOC), resident assessment instrument (RAI) coordinator, registered nursing staff, personal support workers (PSWs), housekeeping member, maintenance department member, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observation on February 6 and 11, 2015, revealed the tub room door in west wing of the third floor to be unlocked.

Interview with the assistant administrator (AA) revealed that there was no lock present on the door. He/she confirmed that a lock should be installed to prevent residents from entering the tub room without supervision. He/she also confirmed that the tub room should be locked when not in use. [s. 5.]

2. Observation made on February 6, 2015, revealed that the door leading to the outside to an unheated greenhouse, from the south side recreation room on the second floor was unlocked and permitted unsupervised access to that area.

Interview with an identified PSW revealed that the door was not locked and he/she locked it immediately.
Interview with the assistant administrator confirmed that the unheated greenhouse's door should be locked at all times to prevent unsupervised access of the residents.
Interview with the administrator confirmed that the unheated greenhouse's door must be locked at all times for safety and to restrict unsupervised access to that area by residents. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

Observation conducted on February 6, 2015, at 10:00 a.m., revealed one window in each of the three dining rooms on the third floor has a screen and opened to 39.5 centimetres (cm). Interview with the director of care (DOC) confirmed that the identified windows in the three dining rooms on the third floor can be opened to greater than 15 cm, which posed a risk for a resident to pass through the opening. The DOC stated he/she was not aware that those windows could be opened greater than 15 cm and confirmed this is a safety risk for residents.

Observation conducted on the same day and interview with an identified maintenance member revealed that the windows in each of the dining room were repaired to prevent opening greater than 15 cm.
Interview with the administrator confirmed that the windows in the three dining rooms on the third floor had been repaired and do not open more than 15 cm. [s. 16.]

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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted.

A review of the plan of care for resident #26 revealed that the home did not complete a post-fall assessment for the fall which occurred on an identified date.

A review of the home's policy #NM-I-042, titled "Falls Prevention and Management Program" revealed that registered nursing staff need to complete a post fall assessment after every fall.

Interview with the registered nursing staff and DOC confirmed that a post-fall assessment was not completed as they were unable to find the copy of a post-fall assessment completed on an identified date for resident #26. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident may be required.

Review of resident #4's MDS assessment records and interview with the RAI coordinator revealed that the resident's MDS completed on an identified date, indicated the resident was continent of urine. On a later date, records revealed resident #4 was occasionally incontinent of urine and seven months later, the resident has been frequently incontinence of urine.

The MDS completed on an identified date, for resident # 28 indicated that the resident was frequently incontinent of urine and was continent of bowel. The MDS completed on another identified date, indicated that the resident was incontinent of urine and bowel.

Review of the point click care electronic documentation (PCC) under tab "Assessment" revealed that both residents who experienced a change in his/her continence status did not receive a Bladder and Bowel Continence Assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident may be required.

A review of the home's policy #NM-1-14, titled "Urinary and bowel continence screening program" indicated that the frequency of assessment for each resident is upon admission to the home and a full seven day assessment (MDS) will be initiated, quarterly and at any significant change in the continence status.

A review of the home's policy #NM-I-020, titled "Continence Care and Bowel Management Program", dated June 2014, indicated that the assessment must include identification of causal factors, patterns, type of incontinence, medication, potential to restore function and identify type and frequency of physical assistance necessary to facilitate toileting.

The RAI co-ordinator revealed that the home is presently using only the MDS for continence care assessment. The MDS assessment does not include all the assessment requirements that are needed to be taken into consideration as indicated in the home's policy and required by the legislation.

Interview with DOC confirmed that the home is not assessing their residents for incontinence using a clinically appropriate tool specifically designed for assessment of incontinence. [s. 51. (2) (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 each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident may be required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Observation conducted on January 6, 2015 at 10:00 a.m., revealed that sporicidal liquid disinfectant was found in an unlocked cabinet inside the unlocked utility room door located on the west side of the first floor. The key was found in the lock of the utility room.

An identified housekeeping member indicated that the cabinet containing the disinfectant and the utility room should be locked at all times and the key to be hung on the hook located outside of the door on the upper left side wall beside the utility room door.

The manufacture's precautionary statement on the sporicidal liquid disinfectant bottle indicated: the product could cause mild skin irritation and moderate eye irritation. If ingested, do not induce vomiting. Call a physician or poison control centre immediately.

Interview with the assistant administrator confirmed that hazardous substances must be kept inaccessible to residents at all times.

Observation made on February 13, 2015, revealed that the above mentioned utility room door was locked and the lock was changed to a touch keypad lock. [s. 91.]

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 hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: 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 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.

Observation on an identified day, revealed that the medication room door on the third floor had the medication cart and narcotic bin keys hanging from the medication room door lock. Medication cart was not locked and the drawers of the cart could be opened. The residents' medication and the narcotic medication were accessible to individuals other than those identified in the legislation.

Interview with an identified registered staff confirmed the medication room door and the medication cart were left opened with the keys in the door which consisted of the medication cart key and narcotic bin key. The medication cart was unlocked and medication was accessible to individuals other than those identified in the legislation. [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 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, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date, resident #15 was observed to remove a small cloth from the glass case. Two yellow medications fell out of the small cloth into the resident's glass case. The identified registered staff was informed by the inspector of the above observations. The identified registered staff identified that the medication were two tablets of bisacodyl.

The registered staff revealed the resident's medication administration record (MAR) indicated the resident receives this medication daily. A review of resident #15's MAR from seven days, indicated the resident is not on a self-administering protocol and the medication had been recorded as administered.

The registered staff was unable to identify when resident #15 did not take the medication and confirmed the medication should not be kept by the resident. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the residents.

Review of the written plan of care on an identified date, indicated to provide one of the two kind of incontinence products during the evening and at night for resident #4.

Interview with an identified personal support worker (PSW) and an identified registered staff revealed that the resident has been wearing two kind of incontinence products during the day and another kind during the night for incontinence.

Review of the new "Continence Management Program" list titled “Medicalmart, on a specific unit”, indicated that the resident should wear a specific incontinence product during the day, evening and night.

Interview with the RAI coordinator revealed that the resident should wear the same specific incontinence product during the day, evening and night as indicated in the Medicalmart list.

Interview with the RAI coordinator confirmed that the plan of care did not provide clear direction to staff and others who provide direct care to the residents. [s. 6. (1) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents are communicated to the Family Council of the home on an ongoing basis.

Interview with the president of the Family Council confirmed that the home never communicated a change in PSW staffing work hours to the Family Council in writing or verbally. The changes were made from September 2014 as follows:
• Day shift: 7:00 a.m. - 3:00 p.m. to 6:00 a.m. - 2:00 p.m.,
• Evening shift: 3:00 p.m. -11:00 p.m. to 2:00 p.m. -10:00 p.m., and
• Night shift: 11:00p.m. -7:00 a.m. to 10:00 p.m. - 6:00 a.m.

A review of the Family Council meeting minutes conducted on September 2014, does not reflect the the communication of this change.

Interview with the administrator indicated that she verbally communicated the staffing shift hour changes to the Family Council during the September 2014 meeting, however she could not provide any record of the communication. [s. 228. 3.]

Issued on this 27th day of April, 2015

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

Original report signed by the inspector.