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
Feb 13, 2015	2015_340566_0002	T-1684-15	Resident Quality Inspection

Licensee/Titulaire de permis

PORANGANEL HOLDINGS LIMITED
2231 MEDHAT DRIVE MISSISSAUGA ON L5B 2E3

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

KING CITY LODGE NURSING HOME
146 Fog Road King City ON L7B 1A3

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

ARIEL JONES (566), SARAH KENNEDY (605), SARAN DANIEL-DODD (116)

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): January 29, 30, February 3, 4, 5, 6, and 9, 2015.

The following critical incident intakes were inspected: T-464-14, T-612-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), quality lead/education coordinator/resident advocate, food services manager (FSM), Resident Assessment Instrument (RAI) coordinator, life enrichment manager, environmental services supervisor (ESS), registered staff members, personal support workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
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
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **13 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.

On January 29, 2015, and subsequently on February 4, 2015, the shower/tub room was observed to be left open, unlocked and unattended. The door to the shower/tub room is not equipped with a lock. Transfer equipment (mechanical lifts) were observed to be stored inside the room. On both occasions the floor of the shower/tub room was noted to be wet in several areas which posed a slip hazard to residents.

Interviews held with personal support workers (PSW) and an identified member of the registered staff confirmed that the shower/tub room is left open as it provides easier access for staff members. [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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

Resident #008 was observed to be seated in a tilt wheelchair in a slightly tilted position with footrests in place on both January 30 and February 4, 2015.

A review of the resident's current care plan (as of February 3, 2015) failed to reveal evidence that the resident requires use of a tilt wheelchair for repositioning or as a personal assistance services device (PASD).

An interview with an identified PSW assigned to the resident confirmed that he/she tilts the resident in his/her chair in order to make him/her comfortable, especially when he/she is watching TV. On review of the resident's kardex, the PSW confirmed that tilting of the resident's wheelchair was not outlined on the kardex.

Interviews with the registered staff and Director of Care (DOC) confirmed that the resident has not been assessed for use of the tilt wheelchair as a PASD, that staff should not be tilting the resident when he/she is up in his/her wheelchair, and that if staff are doing so, care is not being performed as per the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care.

A review of the written plan of care for resident #005 revealed that the care plan included identified interventions related to decreased/impaired vision. This information is not included in the kardex.

An interview with an identified PSW revealed that he/she uses the kardex to verify resident care needs and he/she was unaware that resident #005 had vision impairment.

An interview with a registered staff member confirmed that the PSWs typically use the kardex to access care plan information. Direct care staff are not kept aware of the contents of the vision plan of care for resident #005. [s. 6. (8)]

3. The written plan of care for resident #009 identifies that the resident is at high risk for falls related to multiple identified risk factors. Resident #009 has experienced an identified number of falls between April 2014 and January 2015.

Interviews held with registered staff members and PSWs revealed that they were unaware of the resident's risk for falls and fall history. Staff members indicated that the resident was not at risk for falls. Staff members confirmed they were not aware of the

contents of the plan of care related to falls risk for resident #009. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that staff who provide direct care to a resident are kept aware of the contents of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place is complied with.

The home's policy entitled "Disposal of Discontinued Medication" (revised June 23, 2014), states that the following medications will be identified, destroyed and disposed of including: expired medications, medications that are no longer required due to being discontinued, or when a resident is discharged or deceased.

On February 4, 2015, the medication room was observed to contain a Humulin vial with an expiry date of October 2014. Interviews held with registered staff members and the Administrator confirmed that the medication room is to be reviewed on a monthly basis for expired medications that are to be discarded. [s. 8. (1) (b)]

2. A review of the policy "Management of Methicillin Resistant Staphylococcus Aureus (MRSA)" (#IFC D-45, revised July 10, 2014) revealed "if a single case of MRSA is found, screen other residents in the geographic area of the resident's room and those who have been cared for by the same care providers as the resident with MRSA".

Record review for resident #012 revealed that this resident was not screened for MRSA after his/her roommate received the identified diagnosis.

An interview with the Infection Prevention and Control (IPAC) program lead confirmed that residents in the geographic area of the affected resident were not screened as per the policy. It was confirmed that the expectation is to screen residents as per the policy and therefore the policy was not complied with. [s. 8. (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 to ensure that the following policies are complied with:
- Disposal of Discontinued Medication
- Management of Methicillin Resistant Staphylococcus Aureus (MRSA), to be implemented voluntarily.

WN #4: 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 is maintained in a good state of repair.

On January 30, 2015, at 09:55 a.m. the ceiling just inside room #106 was observed to be patched and unfinished/unpainted. The interior bathroom door in the same room was scraped exposing particle board. On January 30, 2015, at 10:47 a.m. it was observed that the wall behind the entrance doorway of room #111 was scuffed and had two small missing pieces of drywall. On February 3, 2015, at 10:22 a.m. two buckets were observed catching dripping water from the ceiling at the end of the south hallway. These identified areas remained in the same condition for the duration of the inspection.

An interview with the environmental services supervisor (ESS) confirmed that these areas of the home were in disrepair. An interview with the Administrator confirmed that the expectation is for the home to be maintained in a good state of repair. [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 that the home is maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect neglect of a resident by the licensee or staff, resulting in harm or risk of harm, immediately report the suspicion to the Director.

The licensee submitted a Critical Incident (CI) report on an identified date in May 2014, related to an incident of alleged abuse/neglect that took place on an identified date in April 2014.

An interview with the identified staff member who submitted the CI report confirmed that the report was not submitted immediately and that the expectation is that suspected abuse or neglect should be reported to the Director immediately. [s. 24. (1)]

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director under the Long-Term Care Homes Act (LTCHA).

On an identified date in March 2014, resident #034 reported to an identified member of the registered staff that a co-resident had assaulted him/her on an identified date in February 2014. The identified staff member notified the management of the home and the home immediately undertook an investigation into the allegations, which could not be proven.

Staff interviews confirmed that the Director was not notified of the alleged incident of abuse until a CI report was submitted on a later date in March 2014, and that the expectation is to immediately notify the Director of any witnessed or suspected abuse. [s. 24. (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 person who had reasonable grounds to suspect abuse by anyone or neglect of a resident by the licensee or staff, resulting in harm or risk of harm to the resident, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: 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 has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The written plan of care for resident #009 indicates that he/she is at high risk for falls related to multiple identified risk factors.

Interviews held with registered staff members and PSWs revealed that they were unaware of the resident's risk for falls.

Resident #009 has experienced multiple falls over the period of April 2014 to January 2015. Record review revealed and staff interviews confirmed that post fall assessments were not completed for four falls that occurred on identified dates in April, September, and November 2014.

An interview with the home's nursing consultant confirmed that a post fall assessment is to be completed after every fall incident whether or not an injury has been sustained. [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 has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are schedules in place for routine and preventative maintenance.

A review of the "Preventative Maintenance Program Monthly Checklist" revealed that there is no routine and preventative maintenance schedule in place to monitor and ensure that resident rooms are kept in a good state of repair.

An interview with the ESS confirmed that the "Preventative Maintenance Program Monthly Checklist" does not include monitoring resident rooms. [s. 90. (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 to ensure that there are schedules in place for routine and preventative maintenance of resident rooms, 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right not to be neglected by the licensee or staff.

Review of a CI report submitted by the home on an identified date in April 2014 revealed that resident #010 was found by the Administrator wearing a soiled brief and with his/her hands covered in feces. The Administrator cleaned the resident's hands and informed the registered nurse (RN) about the situation. The resident's PSW was on break and the RN told the Administrator that resident #010 would be having a shower right after the identified PSW returned. When the Administrator returned an hour later, resident #010 was still wearing the soiled brief and had not yet been showered. There were no negative outcomes as a result of the delay in care.

An interview with the identified PSW confirmed that resident #010 was not cared for immediately and he/she was left in a soiled brief for over an hour.

Review of the home's "Abuse or Neglect Policy" (#P-10, revised May 25, 2012) classifies leaving a resident in a soiled linen (whether intentional or not) as a form of staff neglect.

An interview with management confirmed that the expectation is for residents to be cared for in a timely manner to prevent neglect and potential harm. [s. 3. (1) 3.]

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:
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 #008 was based on an interdisciplinary assessment of the resident's vision.

The Minimum Data Set (MDS) assessment from an identified date in November 2014, indicated that resident #008 has impaired vision and does not use visual appliances or corrective lenses. The Resident Assessment Protocol (RAP) summary indicated that care planning would be done to address the identified issue. There is no plan of care developed for this problem.

Staff interviews confirmed that if the RAP was triggered for the resident, then the problem should be outlined on the plan of care. [s. 26. (3) 4.]

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menus are communicated to residents.

On January 29, 2015, at 12:30 p.m. it was observed that the weekly posted menu did not match what residents were served for lunch.

The food services manager (FSM) confirmed that the posted menu was incorrect and that the expectation is for the correct weekly menu to always be posted and communicated to residents. [s. 73. (1) 1.]

WN #11: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home.

A review of the home's process for determining satisfaction of residents and families in 2014 involved the use of the stage one questions from Abaqis, plus two additional questions regarding general satisfaction with the home and how likely they are to recommend the home to others (using a scale from one to ten to measure level of satisfaction).

An interview with the quality lead confirmed that the home used the Abaqis survey in 2014 and that the Abaqis tool does not determine satisfaction in all required areas, including occupational therapy and physiotherapy services, and all mandatory programs. He/She further stated that the home is currently in the process of developing a cumulative satisfaction survey for 2015. [s. 85. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review revealed and interview with the Administrator confirmed that the Medical Director did not participate in the annual evaluation of the home's medication management system in 2014. [s. 116. (1)]

WN #13: 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 February 4, 2015, the medication cart was reviewed and observed to contain a hammer, two pairs of scissors, a pack of cigarettes, keys, a flashlight, batteries, and an identified personal item belonging to resident #032.

An interview with a registered staff member confirmed that only drug and drug-related items are to be stored within the medication cart. [s. 129. (1) (a)]

Issued on this 13th day of February, 2015

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

Original report signed by the inspector.