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
Direction de l'amélioration de la performance et de la conformité

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2014	2014_162109_0001	T-47-14	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

SUSAN SQUIRES (109), STELLA NG (507), SUSAN SEMEREDY (501), VALERIE PIMENTEL (557)

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 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON), Registered Dietitian (RD), Food Services Supervisor (FSS), Registered Nursing Staff, Personal Support Workers(PSWs), Housekeeper, Life Enrichment Coordinator, Environmental Services Supervisor, RAI Coordinator, Associate Nurse Manager, Nurse Manager, Physiotherapist (PT), Substitute Decision Makers, Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, completed record reviews for identified residents and staff, observed dining and snack service, observed medication administration, observed resident and staff interactions, reviewed the licensee's policies, reviewed meeting minutes for resident and family councils.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other for Resident #259.
The Minimum Data Set (MDS) Assessment completed on an identified date states that Resident #259 has inadequate control for bowel function, all (or almost all) of the time and requires the use of a medium sized brief.
The home's Continence Care Assessment tool was completed on an identified and indicates that Resident #259 is not incontinent of stool and requires a large sized brief.
Staff interview revealed that Resident #259 is incontinent of bowel functions and requires a medium brief. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
Resident #985 was identified as being positive for an identified bacteria upon admission screening results on an identified date. According to the plan of care the resident must be tested weekly until 3 negative consecutive tests are obtained and then tested every month for 4 months to ensure the resident is bacteria free.
Record review and staff interview revealed the resident did not have the test completed again after the identified date. [s. 6. (7)]

3. The licensee failed to ensure each resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary for Resident #277.

The MDS Assessment indicated that Resident #277 has inadequate control for bowel and bladder functions and requires the use of a large sized brief.
The home's Continence Care Assessment tool indicated that the resident had an indwelling catheter.
Record review indicated that the indwelling catheter was discontinued.
There had been no reassessment of the resident in response to the change in continence status. [s. 6. (10) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that the care set out in the plan of care is provided to the resident as specified in the plan, and each resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 the policy for resident weight monitoring is complied with. Resident weight monitoring policy, index I.D. C-25, in the resident care and services manual, revised May 25, 2012 states that any resident with a weight change greater than or equal to 5% in one month or greater than or equal to 7.5% in 3 months or greater than or equal to 10% in 6 months will be assessed by the RD. According to the home's policy the RD is notified of the weight changes through review of the weight exceptions report.

Resident #239 had a weight loss of 7.9 kg (14%) over a one month period. Record review and staff interviews confirmed that this significant weight loss was not assessed by the RD until the family wanted to try a supplement.

Resident #271 had a weight gain of 7kg (13%) from over a one month period. Record review and staff interviews confirmed that this significant weight gain was not assessed by the RD.
An interview with the RD confirmed that referrals are not received on a routine basis for weight change. [s. 8. (1)]

2. The licensee failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act. Regulation 50 (2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.
The registered staff in charge of the skin and wound program provided a skin and wound policy (from Responsive Health Management revised February 2012) that stated the role of the RD is to receive referrals from the registered staff and/or physician and assess all residents with skin breakdown (stage 2, 3, 4, unstageable) and order nutritional interventions to maximize wound healing. This policy is not in accordance with the regulation that states the RD is to complete an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown.
Resident #239 at high nutritional risk due to weight loss and poor intake who also had been diagnosed as having had an identified bacterial infection was identified as having an open skin tear. Record review and staff interview confirmed that a referral to the RD was not made and an assessment by the RD was not completed. [s. 8. (1)]

3. The licensee failed to ensure that the policy #IFC H-15 titled Hand Hygiene, review date May 2, 2012 states "All employees and volunteers will be in-serviced on hand hygiene during general orientation and also on an annual basis".

Record review of staff education revealed that only 61 percent of all staff attended the annual hand hygiene in-service. [s. 8. (1)]

4. The licensee failed to ensure that the home's drug destruction and disposal policy was complied with.
The home's Drug Destruction and Disposal policy revised on May 25, 2012 states that when destroying narcotics or controlled substances (drugs) the following must be

recorded on the Medisystem Narcotic/Controlled Substances Surplus Drugs record:
- Date of removal from the drug storage area,
- The name of the resident,
- Prescription number,
- The drug's name,
- Strength and quality,
- The reason for destruction,
- The date it was destroyed,
- The names of the person who destroyed the drug,
- The manner of destruction of the drug.

Record review revealed that the Narcotic/Controlled Substances Surplus Drugs record for March 28, August 9, and November 15, 2013 do not include the following information:
- Date of removal from the drug storage area,
- The reason for destruction,
- The names of the person who destroyed the drug. [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 where the Act or 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, is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. and is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The following doors leading to stairways and to the outside of the building are not equipped with audible alarms:
South door exit off of unit
Central (main door)
Side (delivery door)
North exit [s. 9. (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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation, to be implemented voluntarily.

WN #4: 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).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for Resident #262 was based on an interdisciplinary assessment of the resident's vision.
The MDS assessment indicated that Resident #262 has low vision and does not have corrective lenses. The Resident Assessment Protocol (RAP) summary indicated that the resident was responding to the interventions as outlined in the plan of care.
There is no plan of care developed for this problem. [s. 26. (3) 4.]

2. The licensee failed to ensure that the RD who is a member of the staff of the home complete a nutritional assessment for the resident whenever there is a significant change in the resident's health condition and assess the resident's nutritional status, including height, weight and any risk related to nutrition care and hydration status and any risks related to hydration.
Record review revealed and staff interview confirmed that Resident # 239 presented a significant change in his/her health condition over a one month period of time. The change included weight loss of 7.9 kg (14%) over a month, declining intake and diarrhea related to bacterial infection.
The RD indicated that a nutritional assessment was not completed in relation to this change in resident's health status. [s. 26. (4)]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment the resident's vision and shall ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment for all residents whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #5: 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 failed to ensure that when the 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.

Resident #262 was assessed by the PT as high risk to fall and is considered to have a history of falls or risk of falls.
Review of clinical record for Resident #262 revealed that the resident had 15 falls over an 11 month period of time.

Resident #236 was assessed by the PT as high risk to fall.
Review of clinical record for Resident #236 revealed that the resident had 4 falls over a 6 month period of time.

Resident #479 was assessed by the PT as high risk to fall.
Review of clinical record for Resident #479 revealed that the resident had a fall on an identified date.

Interview with Associate Nurse Manager confirmed that post-fall assessment for Resident #262, Resident #236 and Resident #479 has not been conducted using a clinically appropriate assessment instrument that is specifically designed for falls following any of the aforementioned falls. [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 using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Resident #239 at high nutritional risk had significant weight loss of 7.9 kg (14%) over a one month period of time. Record review and staff interviews revealed that this weight loss was not assessed by registered staff or the RD.

Record review revealed that Resident #271 had a weight gain of 7kg (13%) over a one month period of time.
Staff interviews confirmed weight changes are not consistently assessed. [s. 69.]

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 with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff have received retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24.

Review of staff education record revealed that not all staff received the above mentioned required training in 2013.
Attendance record revealed the following:
Only 57 percent of staff completed the home's online training in the home's policy to promote zero tolerance of abuse and neglect of residents.
Only 78 percent of staff completed education on Residents' Bill of Rights.
Only 73 percent of staff completed education on mandatory reporting of complaints.
[s. 76. (4)]

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 persons who have received training under subsection (2) receive retraining in Residents' Bill of Right, the duty to make mandatory reports, the home's policy to promote zero tolerance of abuse and neglect of the resident, and the whistle-blowing protection, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances of an environmental hazard that affects the provision of care or the safety , security or well-being of one or more residents for a period greater than six hours, including a breakdown of major equipment or a system in the home.

The home experienced a power outage from December 21, until December 24, 2013 which affected the functioning of the fire pump system. The pump which supplies water to the hoses in the fire cabinets was malfunctioning and rendering it unable to pump water in the event of a fire. The home has been unable to get the part replaced. The home is waiting for an individual to weld the damaged parts together. The Fire Chief has been notified of the damaged pump.
The Director was not notified of the system breakdown which poses a risk to the residents. [s. 107. (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 Director is immediately informed, in as much detail as is possible in the circumstances of an environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including a breakdown of major equipment or a system in the home, to be implemented voluntarily.

WN #9: 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 failed to ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored to be kept locked at all times, when not in use.

On January 17, 2014 at 1133 hours, the medication cart was observed in the hallway with medication cart keys on the top of the medication cart unattended while the registered staff was administering medication to a resident in the dining room.

On January 20, 2014 at 1338 hours the medication cart was observed in the hallway to be unlocked with no registered staff in immediate vicinity for 25 minutes.

On January 28, 2014 at 0953 hours the medication cart was left unattended and unlocked. Registered staff took pain medication to a resident in his/her room, returned to the medication cart, signed off medications as administered and left again without locking the medication cart and went to the office. [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 so that all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #10: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

Registered staff did not perform hand hygiene practice prior to drug administration on January 16, 2014 at 1205 hours, January 17, 2014 at 1133 hours, and January 20, 2014 at 1615 hours. [s. 229. (4)]

2. The licensee failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission. Record review and staff interview confirmed that Resident #234 was admitted on an identified date and was screened for step 1 tuberculosis mantoux (TB) 4 days later. Step 1 was not read and step 2 was not completed. Record review revealed Resident #234 had step 1 TB repeated 5 months after admission. Record review revealed a chest x-ray was not completed until 8 to 9 months after admission. [s. 229. (10) 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 staff participate in the implementation of the infection and control program and that immunization and screening measures are in place for each resident admitted to the home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential.
On January 15, 2014 at 1012 hours the computer on the medication cart was observed to be open and displaying a resident's personal health information which could be observed by any person walking by. Registered staff admitted that he/she forgot about closing the computer as he/she was checking on supplies. [s. 3. (1)]

WN #12: 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 failed to ensure that the home is a safe and secure environment for its residents.
A pair of pointed scissors was observed hanging from the beverage cart used in the dining room at lunch on January 15, 2014. The scissors were in an open V position that was tied to the cart with plastic wrap. The pointed blades were reachable and accessible to the residents. When brought to the attention of registered staff the scissors were immediately removed. [s. 5.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date a resident room was observed to have no call bell pull cord present in the resident's bathroom. The administrator was informed on the same day.

Over 12 days later the same resident room was observed and the call bell pull cord in the resident's bathroom had not been replaced. [s. 17. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table for all other homes which are not included in the 2009 design manual are maintained at minimum acceptable levels.

The minimum acceptable levels of 215.84 lux is a requirement for all other areas of the home.
Resident bathroom in an identified room shows a reading of 87 lux
Resident bathroom in an identified room shows a reading of 11 lux

The low lighting levels in the resident bathrooms were discussed with the Environmental Services Manager. [s. 18.]

WN #15: 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 :

The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Staff interviews and record review confirmed that staff of the home failed to immediately report abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in risk of harm to a resident to the Director. Resident interview and record review revealed an incident which occurred on an identified date, where Resident #322 reported alleged emotional abuse. Registered staff who was present during the allegation did not report the incident to the Director. Upon learning of the alleged abuse, the home's management team conducted an internal investigation and did not report the incident to the Director. [s. 24. (1)]

WN #16: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a RD who is a member of the staff of the home.
Resident #239 at high nutritional risk due to weight loss and poor intake who also had been diagnosed as having an identified bacterial infection was identified as having an open skin tear. Record review and staff interview confirmed that a referral to the RD was not made and an assessment by the RD was not completed. [s. 50. (2) (b)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a response in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.
Record review of Residents' Council minutes from meetings revealed residents had concerns that were not responded to in writing.
Minutes from October 7, 2013 stated that some residents would prefer more fries being served with meals as well as more salads and it was noted that the Food Service Supervisor who is usually in attendance was not there but would address these concerns upon her return.
Minutes from November 7, 2013 stated that residents would like to see new trivia books and see newer and more challenging questions. Record review found no evidence of any response to these concerns.
Staff interviews revealed that there is a resident concern form that could be used to respond to these concerns but is only being used to document resident special meal request and is not being used to respond to Resident Council concerns or recommendations. [s. 57. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a response in writing within 10 days of receiving Family Council advice related to concerns or recommendations.
Record review of Family Council minutes from meeting on September 16, 2013 revealed concerns that were not responded to in writing. Concerns included having special lunch days for the residents, making crackers available on the table before soup is served, wanting to see more variety of beverages, having name tags more visible to families, having more visiting space for residents who want visitors and eroding parts of the driveway. Interview with the Family Council representative and the staff confirmed that a response in writing to Family Council suggestions and advice is not being provided. [s. 60. (2)]

WN #19: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

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 failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
On an identified date two residents in the dining room during the lunch meal were being assisted by a dietary staff member to eat with a fork. The staff member was standing over the residents to assist with feeding and one resident pushed the fork away with a look of surprise.
On an identified date during the morning snack service in the lounge, Resident #248 was observed being assisted by a PSW to drink a beverage in an unsafe feeding position. Resident #248 was observed in a reclined position in his/her chair and the staff member was standing over the reclined resident to assist with feeding. The resident was lying back in a reclined, resting position and when given liquid to sip from the cup coughed and liquid spilled from his/her mouth.
Staff interview revealed the licensee did not have a policy on safe feeding guidelines. On January 20, 2014 the Food Service Supervisor provided a new policy entitled safe feeding guidelines (original date January 17, 2014) with names of all staff who had been inserviced on this new policy January 17-20, 2014. [s. 73. (1) 10.]

2. The licensee failed to ensure that residents who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required by the residents.

Resident #224 who requires total assistance for eating was served soup on an identified date at the lunch meal and was observed to sit with the soup in front of him/her for 5 minutes before any staff provided assistance. Staff interview revealed that they are not aware that a meal should not be served until someone is available to provide assistance with eating and drinking. [s. 73. (2) (b)]

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

Issued on this 10th day of February, 2014

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

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