Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 29, 2016	2016_398605_0017	024754-16	Resident Quality Inspection

Licensee/Titulaire de permis

NISBET LODGE
740 Pape Avenue TORONTO ON M4K 3S7

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

NISBET LODGE
740 PAPE AVENUE TORONTO ON M4K 3S7

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

SARAH KENNEDY (605), ARIEL JONES (566), NATALIE MOLIN (652), SUSAN SEMEREDY (501)

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): August 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31 and September 1, 2016.

The following critical incident (CI) inspections were conducted concurrently with the RQI: 001981-15 (related to abuse), 029701-15 (related to abuse), 015303-16 (related to abuse), 020341-15 (related to abuse), 019448-16 (related to safe and secure home) and 031393-15 (related to plan of care).

The following complaint inspections were conducted concurrently with the RQI: 023122-15 (related to abuse) and 031941-15 (related to lighting).

During the course of the inspection, the inspector(s) spoke with with the chief executive officer (CEO), director of care (DOC), assistant director of care (ADOC), director of environmental services, director of activation, resident assessment instrument (RAI) coordinator, director of human resources, director of resident & tenant services/social worker, director of finance, director of food services, registered dietitian (RD), registered nursing staff, personal support workers (PSWs), dietary aide, activation staff, residents, substitute decision makers (SDMs), residents' council president and family council representative.

During the course of the inspection, the inspector(s) conducted a tour of the home and observed meal service, medication administration, staff to resident interactions and the provision of care, and reviewed health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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:
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.

Findings/Faits saillants :

1. The licensee has failed to ensure that the locks on resident bedroom and washroom doors can be readily released from the outside in an emergency.

Observations revealed that the home had three different types of locking mechanisms on bedroom and washroom doors. One type was a deadbolt that could be locked from the inside and had a key slot on the outside. Another type was a deadbolt that could be locked from the inside and had only a hole on the outside. A third type was a pushed in type lock from the inside and a small flat object, such as a coin, could be used to open it from the outside.

An observation on August 26, 2016, revealed the bedroom door of room 1154 had a key lock mechanism with a dead bolt. From the inside of the room a latch could be turned to lock the door and on the outside was a place for a key. The room also had a lock on the washroom door that when pushed in from the inside rendered the door locked from the outside which had only a slot (no key). The inspector was unable to access the bedroom when the locking mechanism was engaged.

An observation on the same day revealed that in room 1004 there was a washroom door that had a locking mechanism with a dead bolt. From inside the washroom a latch could be turned to lock the door and there was only a hole on the outside. The inspector was unable to access the washroom when the locking mechanism was engaged.

An observation on August 29, 2016, revealed the bedroom door of room 953 had a key lock mechanism with a dead bolt that could be latched from the inside to render the door locked. It had an opening on the outside for a key. The inspector was unable to access the bedroom when the locking mechanism was engaged.

An interview with PSW #115 revealed that if a resident locks themselves in his/her room or washroom, a PSW will contact the charge nurse who has a key to unlock such doors. The home has nine floors with residents residing on them. An interview with the ADOC revealed that there are three charge nurses during the day and evening shifts that are responsible for three floors each. During the night there are two charge nurses in charge of the nine floors. If a PSW needed to contact a charge nurse to open a locked door, the PSW may have to call the charge nurse to come from another floor.

An interview with RPN #114, who was the charge nurse for floors nine to eleven during the day shift on August 29, 2016, revealed he/she was not aware that he/she had any keys to open resident bedroom or washroom doors. Later in the day, the RPN was able to demonstrate that he/she had a master key that could open resident bedroom doors. The RPN was unable to demonstrate how he/she would open washroom doors in rooms

1154 and 1004 with different locking mechanisms.

An interview with the DOC revealed that he/she was also unsure how to open the washroom door in room 1004 and directed the inspector to contact maintenance. The DOC indicated that in the case of an emergency, if the charge nurses could not open a door, they could always call maintenance even during the night shift. The DOC told the inspector that she did not consider this to be a risk even though valuable minutes may be lost during an emergency situation.

An interview with the director of environmental services (DES) revealed he/she was unaware that long-term care homes often do not have locks on bedroom and washroom doors for safety reasons. The DES explained that some resident bedroom doors still had locks on them as the home used to be a retirement home and only if a resident had a history of using the locks inappropriately, were the locks removed. The DES showed and explained to the inspector that some of the locks were unlocked with a master key, some with an old style skeleton key (locking mechanism with only a hole on the outside) and some with any small/flat object, such as a coin, which fits into the locking mechanism slot. The DES confirmed that the home had resident bedroom and washroom doors that were not readily released from the outside in an emergency. [s. 9. (1) 3.]

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 locks on the resident bedroom and washroom doors can be readily released from the outside in an emergency, to be implemented voluntarily.

WN #2: 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 has failed to ensure that requirements set out in the lighting table were maintained which includes a minimum level of 215.28 lux in resident and shower rooms and 376.73 lux at the bed of each resident when the bed is at the reading position.

Low lighting had been triggered during stage one of the home's 2015 Resident Quality Inspection (RQI) which resulted in intake #031941-15. Low lighting was also triggered in stage one during this 2016 RQI.

The long-term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "in all other homes". A hand held digital light meter was

used (Amprobe LM-120, accurate to +/- 5%) to measure the lux in the above mentioned rooms. The meter was held a standard 30 inches above and parallel to the floor. The lamps and lights were turned to the highest levels and left on for at least 10 minutes. All bedroom, washroom and shower doors were closed at the time of observation in order to eliminate the influence of extraneous lighting on the meter readings. The curtains were closed in the bedrooms however not all light from the windows could be eliminated.

An observation on August 26, 2016, revealed that in room 1154 there were three lamps in the room and one was not working. There was a floor lamp with a tri-light bulb and a small lamp at the head of the bed turned on by touch. The washroom light had an overhead pot light covered by matte opal glass dome. Measurements were as follows:
• At centre of room 40 lux,
• At end of bed by standing lamp 139 lux,
• At head of bed in reading position (nearest to the window) 183 lux,
• In the washroom 345 lux.

An observation on August 26, 2016, revealed that in room 1152 there was a floor lamp with a tri-light and a table lamp on a bed side table with a tri-light bulb. There was no washroom adjoined to this room as the resident uses the shower room across the hall. The light meter measurements were as follows:
• At centre of room 68 lux,
• At end of the bed by standing lamp 81 lux,
• At head of the bed in reading position 307 lux.

An observation on August 26, 2016, revealed that in semi-private room 755 there are two beds. There was a floor lamp by a chair near the end of bed one that had a tri-light bulb and there were also two small table lamps at the end of the bed. There was a table lamp on the bed side table by bed two with a tri-light which was turned on to the highest level. The washroom had a frosted window with no curtains so readings were not taken there. The light meter measurements were as follows:
• At entrance way 30 lux,
• At centre of room 31 lux,
• At head of the bed for bed one in reading position 54 lux,
• At foot of bed two by standing lamp and desk lamps 280 lux,
• By washroom door (door was closed) 36 lux,
• In front of closet by entrance way 16 lux.

An observation on August 26, 2016, revealed that in room 1004 there was one bedside

table lamp on the bed side table which was not a tri-light. The washroom light had an overhead pot light covered by a matte opal glass dome. The door to the washroom was closed. The light meter measurements were as follows:
• At centre of the room 52 lux,
• At foot of the bed 43 lux,
• At head of the bed in the reading position 43 lux,
• In the washroom 35 lux.

Due to the fact that some of the triggered rooms did not have adjoined washrooms and the residents used shower rooms across from their rooms for toileting, light meter readings were taken in these rooms. All shower rooms had pot lights above the sink and in the shower that were covered with matte opal glass domes.

An observation on August 26, 2016, revealed that in the 11th floor shower room light meter readings were as follows:
• In front of sink 40 lux,
• In shower area 57 lux,
• In front of toilet 23 lux,
• In middle of the room 25 lux.
While taking the above measurements, the inspector tripped on a slope that went from the toilet and sink area to the shower area due to the low lighting.

An observation on August 29, 2016, revealed that in the 10th floor shower room light meter readings were as follows:
• In front of sink 43 lux,
• In shower area 56 lux,
• In front of toilet 26 lux,
• In middle of the room 35 lux.

On August 29, 2016, the inspector and the DES observed that in the fifth floor shower room the light meter readings were as follows:
• In front of sink 42 lux,
• In shower area 50 lux,
• In front of toilet 18 lux.

Interviews with the DOC and DES revealed the home was built with no overhead lights in resident rooms. The home has tried to provide many tri-light lamps to overcome this issue. An interview with the DES confirmed he/she is aware the home does not meet the

legislative requirements for lighting in resident rooms, washrooms and shower rooms. [s. 18.]

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 requirements set out in the lighting table were maintained which includes a minimum level of 215.28 lux in resident and shower rooms and 376.73 lux at the bed of each resident when the bed is at the reading position, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Record review of a critical incident report (CIR) revealed that on an identified date, resident #021 was observed inappropriately touching resident #020 in an identified common area. The touching was reportedly witnessed by the nurse in charge and two PSWs who were on the floor at the time. The CIR stated police were not notified but would be if this type of incident occurred again, and that resident #021 would be seen by the home's psychogeriatricians.

A review of resident #021's written plan of care prior to the incident revealed that the resident had a history of inappropriate sexual behaviour (verbalizations) toward staff. Interventions included: two staff to do care at all times, staff were not to lean over resident while he/she is lying in bed because he/she will grab you, and to redirect, change topic, and keep conversation with the resident to a minimum.

An interview with RPN #110 revealed that he/she observed residents #020 and #021 seated in the TV lounge on the morning of the incident. RPN #110 was positioned behind the residents and noticed resident #021 trying to inch closer to resident #020 in his/her wheelchair. He/She then saw resident #021 reach over toward resident #020, lift up resident #020's clothing and squeeze his/her thigh area above the knee. RPN #110 stated further that resident #020 responded by saying "I don't like it, I don't like it, don't do it". When the RPN called out resident #021's name in an effort to get him/her to stop touching resident #020, resident #021 immediately responded by saying, "what what, I didn't touch him/her!"

An interview with PSW #108 revealed that he/she witnessed resident #021 pull up resident #020's clothing and touch his/her upper thigh. PSW #108 revealed further that it appeared as if resident #021 knew what he/she was doing as he/she looked around first in what was interpreted to be a check to see whether there was anyone nearby watching, however, according to PSW #108, resident #021 could not see the staff positioned behind him/her. Both staff members confirmed that the touching of resident #020 by resident #021 appeared sexual in nature, and that prior to this incident, resident #021 had demonstrated inappropriate sexual behaviour toward staff.

A review of the home's investigation notes revealed that, following the incident, resident #021 denied touching the resident inappropriately, stating that he/she was trying to say hello to resident #020 and attempting to help fix his/her clothing which was reportedly riding up. A review of resident #021's written plan of care following the incident revealed that the interventions around the resident's sexual behaviours were updated to indicate that the resident is not allowed to sit in the lounge close to any non-cognitively aware residents due to inappropriate behaviour.

An interview with the DOC and CEO confirmed that this incident met the definition of resident to resident sexual abuse, and that the resident has the right to be protected from abuse in the home. The licensee failed to protect resident #020 from sexual abuse by resident #021. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: 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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based to the Director.

A complaint was received via the MOHLTC INFOLINE on August 16, 2015. The complainant stated an unidentified staff member was shouting at a resident to get out of his/her wheelchair. At the time of the incident the complainant was touring the home with the social worker. An interview with the complainant revealed he/she could not remember details, but said the incident was shocking and upsetting to his/her family member who was also on the tour.

An interview with the former social worker revealed he/she was present at the time of the incident and the incident was reported to the DOC. An interview with the DOC confirmed the incident was not reported to the Director. [s. 24. (1)]

2. A review of an identified CIR revealed that resident #022 was allegedly spoken to in an angry tone and called ugly by a PSW staff member. The CIR revealed the incident was witnessed by an activation staff member on September 12, 2015, at 1800h. This was reported to management staff on October 23, 2015, at 1220h, and was submitted to the Director on October 26, 2015, at 1616h.

An interview with the DOC and director of human resources confirmed the Director had not been notified by management staff prior to October 26, 2015, therefore not immediately reporting the alleged abuse of resident #022 by an identified PSW staff member. [s. 24. (1)]

3. A review of an identified CIR revealed residents #020 and #021 were in the 10th floor common area when resident #021 was observed by identified nursing staff touching resident #020 inappropriately. The CIR revealed the incident occurred on August 1, 2015, at 1015h, and was submitted to the Director on August 2, 2015, at 1515h.

An interview with the DOC confirmed the Director had not been notified by management staff prior to August 2, 2015, therefore not immediately reporting the suspected abuse of resident #020 by resident #021. [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 a person with reasonable grounds to suspect abuse immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of a CIR indicated that resident #040 told his/her substitute decision maker (SDM) that PSW #141 pushed and hit him/her and this was communicated to RPN #103 during a telephone conversation. The PSW had tried to take the resident's telephone out of his/her room. The resident's SDM and the home had an agreement that the telephone was to be removed from his/her room during the evening as he/she was routinely calling the police.

A review of resident #040's progress notes and interviews with RPN #103, PSWs #106 and #141, as well as, the resident and tenant services manager, revealed resident #040 had responsive behaviours related to his/her telephone. The resident would think staff were stealing his/her telephone and this would upset the resident. The resident would often barricade him/herself in his/her room to prevent staff from entering his/her room and if staff tried to take the phone he/she would become agitated and aggressive. According to the staff, the phone is best removed when the resident is at dinner and if the resident takes his/her phone with him/her to dinner or hides it, the staff are to leave the phone with the resident and not try to force it from him/her.

A review of the plan of care for resident #040's responsive behaviours indicated the resident had problematic manner characterized by ineffective coping, anxiety, wanting to go home and loss of control. There is no indication that some of his/her behaviours revolve around the telephone and how staff should deal with this issue.

A review of an email communication between the resident and tenant services manager and the home's DOC and CEO revealed that the resident's SDM was unhappy that the home was not following through with the agreement to take the phone away from the resident in the evening and return it in the morning. An interview with RPN #103 revealed that sometimes the resident does not receive the telephone back in the morning and this may be because some staff are not aware of the plan of care.

Interviews with RPN #103, the resident and tenant services manager and the DOC confirmed that resident #040's plan of care should include his/her responsive behaviours related to his/her telephone and the potential trigger of having it removed. [s. 26. (3) 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 responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques, including safe positioning of residents, are used to assist residents who require assistance with eating.

On an identified date, inspector #605 observed a family member feeding resident #012 during meal service. The family member was feeding resident #012 in an unsafe manner. Resident #012 was not coughing and there were no signs of choking or being in pain. The director of food services was immediately notified and stated he/she would contact the RD and notify the ADOC. The family member was encouraged to stop feeding resident #012.

A review of the resident's plan of care revealed the resident receives an identified diet and requires assistance with eating. A review of the resident's electronic medical records revealed family members had not received previous education on proper assistance with feeding. The RD spoke to the family member after the incident and provided education on safe swallowing techniques. The family member was reminded to: feed one teaspoon of food at a time, feed food and fluid separately, ensure food and fluid is swallowed before providing another teaspoon, stop feeding when resident is not alert and report to nurse if resident chokes.

An interview with the RD revealed she had not observed this family member feeding unsafely in the past but confirmed that the techniques used by the family member on the identified date were not safe. An interview with the DOC confirmed the family member was not using proper techniques to assist the resident with feeding. [s. 73. (1) 10.]

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 proper techniques, including safe positioning of residents, are used to assist residents who require assistance with eating, 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 has failed to ensure that all staff have received retraining annually related to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection.

A review of staff training records and an interview with the director of human resources and the CEO confirmed that three per cent of staff did not receive training in 2015 on the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection.

Record review of a CIR, revealed that on an identified date, activationist #101 allegedly observed an identified PSW speak in an angry tone to a resident in the dining room and call him/her ugly. A review of the home's investigation notes into the incident revealed that activationist #101 failed to report the incident to management staff until later. An interview with activationist #101 confirmed that he/she did not notify the Director him/herself, but later reported the incident to his/her supervisor.

An interview with the CEO confirmed that activationist #101 failed to make an immediate mandatory report of alleged abuse. An interview with the director of human resources confirmed that activationist #101 should have but did not receive retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection in 2015. [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 all staff have received retraining annually related to the following: the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, and whistle-blowing protection, to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the Infection Prevention and Control (IPAC) Program is updated at least annually in accordance with evidence-based practices.

A review of the home's "Licensee Confirmation Checklist Infection Prevention and Control" revealed residents receive a 2-step tuberculosis (TB) test to screen for TB upon admission.

A memo was sent to long-term care homes on April 13, 2013, regarding Toronto Public Health's recently updated recommendations for TB screening in long-term care facilities. As per the 7th edition of the Canadian Tuberculosis Standards, TB skin tests are not recommended to be done routinely upon admission for residents 65 years of age or older. A chest x-ray taken within 90 days prior to admission/on admission within 14 days at a facility for residents over the age of 65 is recommended.

An interview with the home's IPAC lead confirmed that residents receive a 2-step TB test to screen for TB on admission. Residents over the age of 65 are not being screened via chest x-ray as per the current recommendations.

An interview with the DOC confirmed residents are screened for TB using the 2-step Mantoux test. The DOC also confirmed the homes TB policy has not been updated as per evidence-based practices. [s. 229. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Infection Prevention and Control Program is updated at least annually in accordance with evidence-based practices, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

On August 31, 2016, at 1306h, an observation on an identified floor revealed the nurses' station door open and unlocked with no staff in attendance. There was one ambulatory resident in the adjacent lounge. There was a computer opened to a resident's electronic health care records and inspector #501 was able to access all resident records.

An interview with the DOC confirmed that this computer should have been logged off so that residents' privacy could be protected. [s. 3. (1) 11. iv.]

WN #10: 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 the plan of care set out clear directions to staff and others who provide direct care to the resident.

A record review of resident #003's continence care assessment revealed he/she wears an identified incontinent product and requires three to four products in twenty four hours. A review of the resident's continence product record stated the resident use a different type of incontinent product on day, evening and night shift. Inspector #652 reviewed resident #003's visual/bedside kardex report which failed to identify the resident's continence care needs.

An interview with the ADOC confirmed that the expectation is for the resident's kardex and continence care assessment to have been updated to reflect the continence needs of the resident, in order to provide clear direction to staff. [s. 6. (1) (c)]

2. An observation on August 24, 2016, revealed on two occasions resident #004 was sitting in his/her wheelchair with two restraints in place.

A review of resident #004's written care plan, progress notes, physician's orders and the restraint consent form identified one restraint when the resident is in his/her wheelchair to prevent falls. The written care plan did not identify the second restraint.

Interviews with PSW #102 and RPN #110 confirmed the use of the second restraint was to prevent the resident from falling. Staff members #102 and #110 also confirmed the restraint was not identified in the resident's written care plan.

An interview with the DOC confirmed that the expectation is for the resident's written care plan to be updated to provide clear direction to staff. [s. 6. (1) (c)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or is reported to the licensee, is immediately investigated.

A complaint was received via the MOHLTC INFOLINE on an identified date. The complainant stated an unidentified staff member was shouting at a resident to get out of his/her wheelchair. At the time of the incident the complainant was touring the home with the social worker. An interview with the complainant revealed he/she could not remember details, but said the incident was shocking and upsetting to his/her family member who was also on the tour.

An interview with the former social worker revealed she was present at the time of the incident and the incident was reported to the DOC. An interview with the DOC revealed the accused staff member was interviewed and denied the allegation, and no further investigation was conducted. An interview with the CEO confirmed an investigation was not completed. [s. 23. (1) (a) (i)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Record review of an identified CIR revealed that on an identified date, resident #021 was observed touching resident #020's arm and legs in an identified common area. The touching was reportedly witnessed by the nurse in charge and two PSWs who were on the floor. The CIR stated that the police were not notified, and that resident #021 was told that the police would be called if this type of incident happened again.

Interviews with RPN #110 and PSW #108 confirmed that they witnessed resident #021 lift up resident #020's clothing and touch resident #020's upper thigh in an inappropriate and sexual manner.

A review of the home's policy titled Zero Tolerance of Abuse and Neglect (#RCS 7.7.45, revised May 2016) indicates that "the police shall be notified immediately of any alleged, suspected or witnessed incident of abuse or neglect of a resident, if the CEO or designate suspects may constitute a criminal offense."

An interview with the DOC and CEO confirmed that this incident met the definition of resident to resident sexual abuse and that in this instance the police were not notified because there was no injury sustained to resident #020. Both the DOC and CEO confirmed that the police would be notified if there was another incident of inappropriate sexual touching by resident #021. [s. 98.]

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 in a medication cart that is secure and locked.

On August 31, 2016, at 1306h, an observation on an identified floor revealed the nurses' station door open and unlocked with no staff in attendance. There was one ambulatory resident in the adjacent lounge. Medications were found in an unlocked cupboard and unlocked fridge which included: lantus, dulcolax, vitamin B12 injections, lactulose, eye drops, inhalers, dexidin 4 detergent, vitrub analgesic ointment. Some prescribed medications included: taro-mupirocin ointment (antibiotic) and fucidin cream.

An interview with the DOC revealed that this room is kept open for PSWs to document on flow sheets but that the cupboard and fridge that contained medications should have been locked. [s. 129. (1) (a) (ii)]

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 19th day of October, 2016

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

Original report signed by the inspector.