Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2015	2015_370162_0015	032439-15	Resident Quality Inspection

Licensee/Titulaire de permis

NORWOOD NURSING HOME LIMITED
122 TYNDALL AVENUE TORONTO ON M6K 2E2

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

NORWOOD NURSING HOME
122 TYNDALL AVENUE TORONTO ON M6K 2E2

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

TIINA TRALMAN (162), SARAH KENNEDY (605), SLAVICA VUCKO (210)

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): November 23, 24, 25, 26, 27, 30, December 1, and 2, 2015.

During the Resident Quality Inspection (RQI), critical incident #026721-15 was inspected concurrently. During the resident quality inspection (RQI), the inspectors conducted an initial tour of the home, dining observation, reviewed resident health records, staff schedules, policies and procedures, observed medication administration, staff to resident interactions and care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), MDS/RAI Coordinator, Resident Services Coordinator, Food Service Manager, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), cook, housekeeping staff, maintenance staff, Social Worker, Activity Director/Residents' Council Assistant, Residents' Council President, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

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

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

Specifically failed to comply with the following:

s. 6. (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).

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 has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #033's written plan of care between identified dates from December to August, 2015, revealed conflicting information. The written plan of care revealed: the resident was unable to bathe him/herself due to physical limitations, required one-person assist, required total assistance by staff, and always two staff required to bathe and give care. The section for transferring indicated two staff to use sit-stand lift, and if the resident is drowsy, staff to use the mechanical lift-hoyer.

A review of an identified critical incident report revealed that on an identified date in September 2015, at an identified time, while two staff members were transferring the resident from the wheelchair to bed, the resident was observed making facial grimaces, and appeared to be in pain. The resident was sent to hospital and was diagnosed with an injury. The cause of the injury was unknown.

An interview with PSW #118 indicated that when the resident had a shower at an

identified time of the incident, he/she was transferred from the wheelchair to the shower chair using the sit-stand lift assisted by two PSWs, and the shower was performed by one PSW. PSW #118 indicated that usually, during morning care, the resident was transferred using the sit-stand lift, as the resident was able to weight bear, hold the lift handles, and follow instructions.

An interview with PSW #117 indicated that during evening care, the resident was always transferred using the hoyer lift because he/she was unable to stand stable, had crossed legs, was unable to hold the lift handles of the sit-stand lift, and was unable to follow instructions in order to perform a safe transfer.

An interview with registered nursing staff #100 and #115 revealed that the resident was being transferred by a hoyer lift for an unidentified period of time prior to the incident. The registered staff further indicated that a logo indicating that the resident is to be transferred using a hoyer lift has been posted on the wall of the resident's room for an unidentified period of time prior to the incident.

A review of the resident's written plan of care for the period before the identified incident, and interviews with the PT, PSWs #117 and #118, registered staff #100 and #115, MDS/RAI Coordinator, and the DOC confirmed that the written plan of care did not give clear direction to staff who provide direct care to the resident in regards to bathing and transferring. [s. 6. (1) (c)]

2. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

A record review of resident #005's flow sheets for September 2015, and the continence assessment from an identified date in September 2015, revealed that the resident is continent of bowel.

A review of the resident's written plan of care indicates he/she is occasionally incontinent of bowel with interventions including wearing an incontinent product, and staff directing the resident to the toilet after each meal and prior to bedtime.

An interview with the resident revealed that he/she is continent of bowel and that he/she toilets self independently. Interviews with PSW #102 and registered staff #100 indicated that the resident is continent of bowel, and no longer wears continence products and that

he/she can toilet self.

An interview with the MDS/RAI Coordinator confirmed that resident #005's written plan of care was not revised to reflect the resident's current continence level. [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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, and to 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 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. 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 the lighting requirements set out in the lighting Table to this section are maintained.

On November 30, 2015, at approximately 9:00 a.m., inspector #210 observed residents in the first floor lounge/dining area eating their breakfast. The ceiling lights were on and the room appeared dark.

On December 1, 2015, at 10:00 a.m., inspectors #162 and #605 used the home's light meter (model LM-81LX), and the lighting within the room measured from 17.22 to 69.95 lux (average 40.5 lux). Staff member #106, who measures lighting in the home, was present.

On December 1, 2015, at 1:20 p.m., inspectors #162 and #605 used the home's light meter (model LM-81LX), and the lighting within the room measured from 35.51 to 73.17 lux (average 53.8 lux). The Assistant Administrator was present and revealed that some lights had been replaced.

The home's Assistant Administrator confirmed that these readings do not meet the lighting requirements set out in the lighting table in the Long Term Care Homes Act (LTCHA) Regulations. [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 that the lighting requirements set out in the lighting Table to this section are maintained, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal.

On November 23, 2015, at 12:15 p.m., in the main dining room, resident #013 was provided a glass of thickened apple juice served in a specified cup. The resident asked for orange juice but staff #104 said there was only apple juice left. Other residents in the dining room were offered orange juice.

Inspector #605 asked staff #104 why resident #013 was not offered a choice between apple juice and orange juice. Staff #104 said only pre-portioned thickened apple juice served in specified cups were left. Staff #104 then went into the kitchen and returned with a specified cup of thickened orange juice and served it to the resident.

An interview with the FSM confirmed that resident #013 should have been offered a choice between apple juice and orange juice. [s. 71. (4)]

2. On November 23, 2015, at 12:15 p.m., in the main dining room, four identified residents were observed receiving their meals without being offered an alternate choice. Three of the four residents were on an identified texture diet, and one resident was on a different texture diet.

An interview with staff #110 revealed that no alternate choices were offered to residents.

An interview with the FSM confirmed that alternate choices are available for identified textures and should be offered to residents. [s. 71. (4)]

3. On November 23, 2015, at 12:15 p.m., it was observed in the main dining room that residents were not served raspberry mousse for dessert as per the posted daily and weekly menu.

An interview with staff #110 confirmed that a Tiramisu dessert was offered instead of a raspberry mousse.

An interview with the FSM confirmed that the expectation is for planned menu items to be offered and available at each meal. [s. 71. (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 planned menu items are offered and available at each meal, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy "Pharmacy Policy & Procedure Manual for LTC Homes" is complied with.

A review of the home's policy "Pharmacy Policy & Procedure Manual for LTC Homes, Section 6, Monitored Medications, Combined Individual Monitored Medication Record with Shift Count", dated January 2014, indicated that registered staff are to sign the "Combined Individual Monitored Medication Record with Shift Count" each time a dose is administered. The registered staff is to include the date, time, amount given, amount wasted, and new quantity remaining. At shift change, two registered staff (leaving and arriving), together:
a) Count the actual quantity of medications remaining
b) Confirm actual quantity is the same as the amount recorded on the last entry of Quality/Remaining
c) Record the date, time, quantity of medication and sign.
(Shift count is a means to regularly audit the individual count for accuracy).

A review of resident #033 and #034’s identified medication administration record of an identified date in November 2015, revealed that the identified medication was given to the residents according to the physician's order and the electronic medication administration records (eMAR) was signed. A review of the "Combined Individual Monitored Medication Record with Shift Count" form revealed that the section for the individual count was not signed at the time the medication was administered and the medication count was not updated.

An interview with registered staff #107 revealed registered staff would sign the individual count section on the "Combined Individual Monitored Medication Record with Shift Count" form at the end of the shift, and update the medication count upon counting the medications with the arriving registered staff member.

An interview with the DOC indicated when monitored medications are administered, the "Combined Individual Monitored Medication Record with Shift Count" form (the section for the individual count) should be signed at the time of medication administration. The DOC confirmed that the policy "Combined Individual Monitored Medication Record with Shift Count" was not complied with. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

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

On November 24, 2015, an observation and an interview with resident #009 revealed that there was no pull string attached to the resident's bedside overhead light, and the resident is unable to turn the light on.

A review of the second floor maintenance repair log revealed that on July 2, 2015, documentation was made regarding no pull string on the overhead light in resident #009's room. However, there was no indication that action was performed to repair the light.

An interview with staff member #114 revealed he/she was aware of the non-functioning light.

An interview with the Assistant Administrator revealed that the light was not functioning and the expectation is that lights are maintained in a good state of repair.

2. On November 24, 2015, an observation and an interview with resident #010 revealed the bottom light of the resident's bedside overhead light was not functioning. The resident requested the inspector to have it fixed.

A review of the second floor maintenance repair log revealed no documentation regarding resident #010's non-functioning bottom bedside overhead light. A review of the resident room audits of identified dates between March and July 2015, revealed resident #010's bottom bedside overhead light was identified as not working.

An interview with staff member #114 revealed that he/she was not aware of the non-functioning light.

An interview with the Assistant Administrator revealed that the resident room audit form is completed bi-monthly, and that the expectation is that any repairs required are to be documented into the maintenance repair log for action to be taken. It was confirmed that the light was not maintained in good repair. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of the minimum data set (MDS) quarterly assessment from an identified date in March 2015, revealed that resident #005 was identified as continent of bowel. The MDS quarterly assessment from an identified date in June 2015, revealed that the resident was frequently incontinent of bowel.

A record review of the flow sheets for June 2015, indicated resident is incontinent of bowel. Interviews with PSW #102 and registered staff #100 revealed that the resident had experienced a change in bowel continence related to a change in the resident's health condition and confirmed that there was no continence assessment completed for the resident at that time.

Interviews with registered staff #100 and the MDS/RAI Coordinator confirmed that there was no continence assessment completed for the resident when there was a change in bowel continence and the expectation is that this form is to be completed when there is a change in the continence status. [s. 51. (2) (a)]

WN #7: 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 has failed to ensure that the licensee responds in writing within 10 days of receiving Residents’ Council advice related to concerns or recommendations.

A review of the Residents’ Council meeting minutes revealed that concerns have been brought forward at the Residents’ Council meetings over the past 3 months.

An interview with the Residents’ Council President revealed that the home had not provided written responses within 10 days from receiving the concerns.

An interview with the Residents’ Council assistant revealed that “Residents’ Council Follow-up” forms are not being completed and members of the Residents’ Council do not receive responses in writing within 10 days of bringing forward a concern or recommendation.

An interview with the Assistant Administrator confirmed that the expectation is for members of the Residents’ Council to receive a response in writing within 10 days. [s. 57. (2)]

Issued on this 9th day of December, 2015

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

Original report signed by the inspector.