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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2014	2014_188168_0012	H-000445-14	Resident Quality Inspection

Licensee/Titulaire de permis

PARKVIEW HEALTH CARE PARTNERSHIP (THE)
284 SUNSET DRIVE, OAKVILLE, ON, L6L-3M4

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

PARKVIEW NURSING CENTRE
545 KING STREET WEST, HAMILTON, ON, L8P-1C1

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

LISA VINK (168), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582)

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): April 28, 29, 30, May 1, 2, 6, and 7, 2014.

This Inspection Report includes findings of non-compliance related to critical incident inspection, log number H-000354-14, which was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered nursing staff, Personal Support Workers (PSW's), nursing students, the Resident Assessment Instrument (RAI) Coordinator, Food Service Manager (FSM), Environmental Services Manager (ESM), Programs Manager, dietary, housekeeping and laundry aides, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, and reviewed relevant documents including but not limited to: clinical records, policies and procedures, menus and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. 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 did not ensure that the home was a safe and secure environment for its residents.

A. On April 28, 2014, at 1100 hours, the laundry chute on the second floor was noted to be unlocked. Interview with direct care staff confirmed that the lock on the laundry chute had been missing. Maintenance was notified of the open chute at 1106 hours, and at 1248 hours, a temporary fix was provided until the part required was received. The laundry chute was noted to be locked and in working order at 1300 hours. (528)
B. On April 28, 2014, at 1035 hours, the door to laundry chute on the fourth floor was noted to have a facecloth in the chute door preventing it from locking. The DOC was made aware of the concern and confirmed that the door was not locked. PSW staff confirmed that the cloth had been placed in the door, as the lock was sticking. The ESM was notified of the concern by the DOC and fixed the lock to the laundry chute at 1105 hours. (582) [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (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. (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 written plan of care did not set out the planned care for the resident.

The plan of care for resident #52 did not include information for staff regarding the level of assistance to be provided at meal times. Interview with registered staff confirmed that the plan of care did not include a focus statement related to eating. [s. 6. (1) (a)]

2. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. Resident #24 had a history of bladder incontinence with urinary retention. The coding completed for the Minimum Data Set (MDS) quarterly assessments for three

recent quarters, related to urinary incontinence identified that the resident was usually continent or occasionally incontinent of bladder. Review of the progress notes revealed that the resident was not continent or incontinent related to the use of a device. Interview with the RAI Coordinator confirmed that the coding and progress notes were not consistent and did not complement each other. [s. 6. (4) (a)]

3. The resident was not 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 changed or care set out in the plan was no longer necessary.

A. The plan of care for resident #13, identified under the focus statement related to a therapeutic diet, diabetes, the need for a modified diabetic diet, regular texture. The resident was changed to a pureed diet on return from hospitalization in 2013. Interview with nursing staff confirmed that the diet, under the identified focus statement, was not revised with changes in the resident's care needs.
B. Resident #13, was observed to be edentulous on April 28, and 30, 2014. PSW's interviewed identified that since recent changes in status the resident no longer wore their full dentures. The plan of care in place on April 30, 2014, identified that staff were to remind the resident to clean their dentures or ask for assistance, and that they wore their dentures at all times. Interview with nursing staff confirmed that the plan of care was not revised with the change in the resident's care needs.
C. The plan of care identified that resident #13 did not use any bed rails. The resident was observed in bed using two, bed rails, in the raised position on April 28, 29, and 30, 2014. Interview with registered staff confirmed that the resident currently used two rails for safety, since a recent hospitalization. The staff member identified that the resident should have been assessed for the rail use, prior to their implementation, and that this would be recorded in the progress notes. A review of the notes did not include an assessment specifically related to the use of the rails.
D. Resident #21 was observed without glasses during the course of the inspection, which the family reported were lost. Interview with staff confirmed that the resident no longer wore glasses as they kept removing them, however could not confirm what had happened to them. The plan of care in place on April 30, 2014, identified under a focus statement related to impaired vision to ensure that eyeglasses were clean and being worn and under an intervention for falls management to ensure glasses were on. The plan of care was not revised with the change in the resident's care need. [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 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 #3: 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 home, furnishings and equipment were not kept clean and sanitary.

A. Resident #21 used a wheelchair for transportation and seating. The chair cushion was noted to have evidence of a dried on liquid and soiling on the tires on April 30, 2014. The Nightly Cleaning Schedule identified that staff were to sanitize the resident's chair on Sundays. On May 6, 2014, the chair cushion was observed and still had evidence of the dried on liquid and soiling on the tires. Interview with the nursing staff confirmed that the chair should have been cleaned by the night staff as per the schedule. (168)
B. On May 2, 2014, the kitchen was observed and identified to be in need of a deep cleaning, which was confirmed by the FSM. The home had cleaning schedules in place, however it was observed that the walls, floors, back-splash, fridges, tops and sides of appliances, garbage cans etc. required cleaning. The dry storage area had a layer of dust on the vent. The kitchen was toured a second time on May 7, 2014, and it was identified that a deep clean had already been initiated by staff. (156) [s. 15. (2)

(a)]

2. The licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A. The communication and response system in the sitting rooms on the second, third and fourth floors were noted to be in disrepair on May 1, 2014, which was confirmed by staff interview and testing. Tour of the second and third floor sitting rooms on May 2, 2014, with the DOC confirmed that the bells would not activate when turned to the "on" position. Interview with the Administrator and DOC confirmed they were not aware that the system was not working and the cause might have been from recent cosmetic changes made to the identified areas. Interview with the ESM on May 6, 2014, confirmed that the home had brought in an outside contractor to correct the situation. (168)
B. Bathroom sinks for residents #52 and #55 were not maintained in a good state of repair. The sink in the bathroom of resident #52 had evidence of corrosion around the drain and in two other areas of the basis as well as a chip in the porcelain. The sink of the bathroom of resident #55 had evidence of corrosion and minor cracking around the drain. Interview with the ESM confirmed that the home had a preventative maintenance program which included sink replacement and plans to replace the identified sinks, by May 8, 2014. (168)
C. On April 28, 2014, it was noted that the caulking around the sink and vanity in resident #10's bathroom was peeling away with large cracks. The ESM inspected the sink and identified that the caulking would be replaced on May 7, 2014. (528)
D. A corner ceiling tile was missing from the shower room on second floor leaving a hole in the ceiling, on April 28, 2014. The ESM confirmed that the tile had been reinserted on May 6, 2014, and confirmed that ceiling tiles were part of the preventative maintenance program. (528)
E. The flooring in the dry storage area, located in the kitchen, was observed to have a very large chip in it near the floor drain that would present as a safety hazard and make it impermeable to cleaning. The ESM confirmed on May 6, 2014, that he was aware of the area and plans to repair the area on May 8, 2014. (156) [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition, in a good state of repair and are kept clean and sanitary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that staff used safe transferring techniques when assisting residents.

In 2014, resident #30 sustained a laceration during a mechanical lift transfer. According to the document that the home referred to as the care plan, the resident was to have three staff present during all mechanical lift transfers. Interview with a PSW identified that the laceration was sustained during the transfer and that only two staff were present at the time that the injury occurred. (582) [s. 36.]

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 use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #5: 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 did not ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. On April 28, 2014, resident #16 was observed to have a bruise. Review of the plan of care on May 6, 2014, did not include any documentation of the bruise. Interview with staff confirmed that registered staff were informed of the bruising on April 30, 2014, and it was not assessed using a clinically appropriate assessment instrument.
B. On April 28, 2014, resident #19 was observed to have an area of altered skin integrity, a dried scab. On April 30, 2014, it was noted that a dressing had been applied to the area. Review of the plan of care on May 6, 2014, did not include any documentation of the area or the dressing. Interview with registered staff confirmed that they were aware of the area on April 30, 2014, and it was not assessed using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

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 that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure that for each resident who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A. On April 28, 2014, resident #40 was observed in an altercation with resident #41. This incident was immediately reported to a PSW, who intervened according to the plan of care. Review of the plans of care for both residents, two days later, did not include any documentation of the incident. Interview with registered staff confirmed that they were notified of the altercation by PSW staff on April 28, 2014, however, did not document the incident, interventions taken, or the resident's responses. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident who demonstrates responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (1) This section and sections 69 to 78 apply to,
(a) the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act; and O. Reg. 79/10, s. 68 (1).
(b) the organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).

Findings/Faits saillants :

1. There was not an organized program of nutrition care and dietary services.

The noon meal service start time was noted to be 1230 hours, however, meal service was observed to be very lengthy in the main dining room, when observed. The home had a very large dining room consisting of 25 tables and one steam table from which all of the entrees were plated.
A. On May 2, 2014, the noon meal was observed starting at 1230 hours. At 1300 hours, it was noted that 18 of the 25 tables had not been served their main entrée. At 1315 hours, 45 minutes into meal service, there was still three tables that had not been served the main entree and residents voiced concerns regarding the length of time they had to wait for their meals. Staff indicated that there was a table rotation in place, however it was not by table number, it was done in three different sections of the dining room.
B. On May 6, 2014, the meal service in the main dining room was found to be lengthy. At 1305 hours, there were still ten of the 25 tables that had not had their entrée choices taken. Residents at an identified table did not have their choice of entrée presented until 35 minutes after the start of meal service. The residents identified that this was usual practice and felt that they were always served last. This table was also observed to be one of the last served during the observed meal service on May 2, 2014. Residents at the identified table were observed to receive their dessert prior to the completion of their main entrée. Some residents who had finished their meals had left the dining room prior to others just receiving their entrees and/or desserts. Staff reported that two residents who normally consume seconds had left without receiving dessert. [s. 68. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure an organized program of nutrition care and dietary services, to be implemented voluntarily.

WN #8: 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. Not all planned menu items were offered and available at each meal and snack.

A. On May 2, 2014, the kitchen ran out of regular and puree textured strawberries, which were part of the main entrée during the observed noon meal in the main dining room.
B. On May 6, 2014, the kitchen ran out of puree texture chicken and regular texture winter vegetables during the observed noon meal in the main dining room.
C. On May 6, 2014, at the noon meal service in the main dining room the kitchen ran short of six individual portions of mousse for dessert and puree texture strawberry rhubarb was available instead. [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 and snack, to be implemented voluntarily.

WN #9: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Not all food and fluids were served at a temperature that was both safe and palatable to the residents.

On May 2, 2014, during the observed lunch meal in the main dining room, cold foods were not found to be in a safe temperature zone, below 40 degrees Fahrenheit (F). Near the conclusion of the meal service, sandwiches were probed at 42.8 degrees F, puree bread was found to be at 60.4 degrees F, minced salad was probed at 46 degrees F, and puree turkey was probed at 45.3 degrees F. [s. 73. (1) 6.]

2. Not all meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

During the observed lunch meal in the main dining room on May 6, 2014, four identified tables were still eating their entrees when served dessert at 1325 hours. The plans of care for residents #52, #56 and #57 were reviewed and their assessed needs did not include serving the dessert at the same time as the entree. [s. 73. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids were served at a temperature that was both safe and palatable to the residents and to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs, 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 did not ensure that the staff participated in the implementation of the infection prevention and control program.

A. On April 28, 2014, from 1233 to 1330 hours, the noon meal service was observed in the second floor sitting room. Hand sanitizer was available on the wall outside of the dining area where the steam wagon was located. During the meal service, two PSW's and one instructor served the entree, cleared the dishes, scraped uneaten food from dishes, and then served the dessert in the sitting room. Hand hygiene was not completed at any time during the observed dining service. [s. 229. (4)]

2. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

A review of three resident's immunization records, who were admitted to the home in 2013, identified that two of the residents were not screened for tuberculosis (TB) within 14 days of admission, or 90 days prior to admission. TB screening was initiated 33 days after admission to the home for resident #32, and 28 days after admission for resident #33. The Infection Control Policy - Tuberculosis Detection and Management, dated March 2014, indicated that all residents admitted to the home would be screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available. [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 the staff participate in the implementation of the infection prevention and control program and to ensure that each resident admitted to the home is 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, to be implemented voluntarily.

WN #11: 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 did not ensure that a person who had reasonable grounds to suspect that 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 immediately reported the suspicion and the information upon which it was based to the Director.

Review of the records for resident #41 identified three incidents of resident to resident abuse which were not reported to the Director:
i. In 2013, resident #41 and resident #42 were involved in an altercation resulting in a scratch.
ii. In 2014, resident #17 struck resident #41 resulting in bruising.
iii. On a second date in 2014, resident #43 hit resident #41 resulting in a bruise.
Interview with the DOC confirmed that the three incidents of resident to resident abuse were not reported to the Director. [s. 24. (1) 2.]

WN #12: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks.

According to the plan of care, resident #10 required two rails in the raised position when in bed for mobility and safety. A review of the clinical record did not include an assessment of the safety risks related to the bed rails being used. The DOC confirmed that bed entrapment risk was evaluated in June 2013, however there was no formalized nursing assessment for bed rails completed, that this information would be included in the progress notes. [s. 26. (3) 19.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

The plan of care for resident #22 identified that an identified intervention was to be completed weekly by PSW staff. A review of the point of care (POC) records for the past 30 days did not include documentation to reflect the intervention was completed. Registered staff interviewed confirmed that this task was not included in the kardex, which was linked to POC, and for this reason there was no documentation of this intervention. [s. 30. (2)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a PASD described in subsection (1) was used to assist a resident with an routine activity of living only if the PASD was included in the resident's plan of care.

Subsection 33(4)4 of the Long Term Care Homes Act identified that the use of a personal assistance device (PASD) may be included in the plan of care only if it was consented to by the resident or substitute decision maker (SDM) with the authority to give consent. Resident #24 was identified in their plan of care and observed to require both bed rails raised in bed for safety and positioning. Review of the clinical record did not include consent for bed rails, which was confirmed during an interview with registered staff. [s. 33. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

A. On April 28, 2014, and during the course of the inspection, lingering offensive odours were noted in the hallway in front of resident's #17 and #44 rooms. Housekeeping staff confirmed that they were aware of the odour and had increased room/bathroom cleaning for resident #44. Interview with the Administrator indicated that they were made aware of the odours on May 5, 2014, and implemented additional cleaning services and ordered additional air fresheners. The odours continued to be present in the affected areas despite the ongoing efforts of the home. [s. 87. (2) (d)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. Not all residents who took any drug or combination of drugs, were monitored and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On May 1, 2014, a portion of the noon medication pass was observed. Resident #53 was administered tylenol, which was not a regularly scheduled medication for the noon medication pass. The registered staff did not document the administration of this medication until approached by the inspector on May 2, 2014, at which time a note was made for May 2, 2014. There was no record of any monitoring of the resident or their response on May 1, 2014, as confirmed by the registered staff. [s. 134. (a)]

Issued on this 16th day of May, 2014

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

I VINK