Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

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

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
Sep 5, 2014	2014_235507_0014	T-000085-14	Resident Quality Inspection

Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East, TORONTO, ON, M1L-1W1

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

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST, SCARBOROUGH, ON, M1L-1W1

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

STELLA NG (507), SOFIA DASILVA (567), THERESA BERDOE-YOUNG (596), TIINA TRALMAN (162)

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): July 24, 25, 28, 29, 31, and August 1, 5, 6, 7, 8, 11 and 12, 2014.

This inspection occurred concurrently with complaint inspections #2014_235507_0015 (T-666-14), #2014_324567_0013 (T-250-14) and T-548-14.
PLEASE NOTE:
The following area of non-compliance related to resident #06 was found and issued in the Complaint Inspection report #2014_235507_0015:
1. O.Reg. 79/10, s.101(2) related to dealing with complaints.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DORC), resident care managers (RCMs), informatics specialist (MDS RAI), infection prevention and control manager (IPCM), building services and security manager (BSSM), recreation manager, registered dietitian (RD), food services supervisor (FSS), nutrition and food manager (NFM), cooks, dietary aides (DAs), housekeeping aides (HKAs), registered nursing staff, resident assistants (RAs), activation assistant, restorative assistant, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in the home and resident's areas, conducted observation in care delivery processes, conducted observation in food production, conducted observation in meal services, reviewed the home's records, policies and procedures, reviewed minutes of the Family Council, Residents' Council and Food committee and reviewed residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
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

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

s. 6. (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the

resident.

On an identified date, the inspector observed two quarter bed side rails in the up position in an identified resident’s bed with the resident in bed.

Interview with the identified registered staff confirmed that two quarter side rails are used when the identified resident is in bed for safety. Interview with an identified resident assistant (RA) confirmed that one quarter side rail is used when the identified resident is in bed for safety.

Interviews with the resident care manager (RCM) and the director of resident care (DORC) confirmed that two quarter side rails are used when the identified resident is in bed for emotional support upon the request of the family.

Record review revealed that the use of bed side rails is not included in the identified resident's written plan of care. [s. 6. (1) (c)]

2. A second identified resident was identified at nutrition risk.

Record review revealed that the second identified resident’s care plan of an identified date, which indicates the second identified resident's diet, is not consistent with the diet information that is listed on the servery diet sheet.

Meal time observation and interviews with identified RAs revealed that the second identified resident is provided meals according to the diet sheet, not the care plan.

Interviews with the food services supervisor (FSS) and the registered dietitian (RD) confirmed that the information is inaccurate on the servery diet sheet. [s. 6. (1) (c)]

3. Review of assessment records of an identified date, indicates that the third identified resident is at risk related to no visual correction. The assessment includes that the resident sees large print, but not regular print in newspapers or books. The assessment further states that a detailed visual assessment could not be performed relating to severe cognitive impairment, but the resident's visual function will be addressed in the care plan.

Review of the care plan, dated eight days after the above mentioned assessment was conducted, includes that the environment will be kept free of small objects and clutter.

Interviews with the RAs and registered staff revealed that staff are not aware of the third identified resident's visual impairment. Interviews with the DORC and the informatics specialist revealed that the third identified resident was coded as unable to see regular print. The DORC further stated that the expectation would have been that interventions related to visual impairment would have been more detailed in nature, for example containing information to verbally cue the resident during meals and when performing tasks. [s. 6. (1) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, the inspector observed the grab bars in three identified bathrooms of resident rooms, and beside the toilets in the spa rooms in an identified unit. The grab bars were loose. Furthermore, a hole was observed starting to form in the wall where the grab bar is attached beside the toilet in the spa room in another identified unit. The administrator was informed of the loose grab bars.

Six days later, the inspector observed the above mentioned grab bars were fixed. [s. 15. (2) (c)]

Additional Required Actions:

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

During interview, the DORC and the administrator confirmed that an identified RA received disciplinary action as a result of the investigation of a complaint from a family member of an identified resident, regarding inappropriate behaviour towards the resident during care, the identified RA made derogatory remarks towards the resident, and roughly pushed the resident onto his/her side.

Record review and interview with the administrator confirmed that the staff received a letter of discipline from the home for speaking to the identified resident in an inappropriate manner during care. [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 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the dental and oral status, including oral hygiene, for the resident.

Interview with an identified resident indicates that the resident does not receive oral hygiene assistance. A review of the assessment records of an identified date, indicates that daily mouth care is to be performed by the staff or the resident. A review of the care plan, dated three months after the above mentioned assessment was conducted, indicates that the resident uses dentures. The care plan states that the resident is able to brush his/her dentures with set up help at the bathroom sink. The care plan does not include information relating to mouth care requirements for the resident.

Interviews with the RAs and the registered staff revealed that the resident is sometimes asked to rinse his/her mouth with water by some RAs. Interview with the registered staff confirmed that the identified resident’s care requirements relating to mouth care were not known. The registered staff confirmed that mouth care as well as denture care should be provided to the resident; however, the resident's plan of care does not include oral hygiene. [s. 26. (3) 12.]

2. The licensee has failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the nutritional status, including weight and any risks relating to nutrition care, for the resident.

On an identified date, a diet order was written to change an identified resident’s nutritional supplement. Record review and interview with the RD confirmed that a nutritional assessment was not carried out to determine the appropriateness of the change to the resident's nutritional supplement.

Observation of a second identified resident at meal times and interviews with identified RAs revealed that the resident receives modified portions.

The second identified resident was identified as being at nutritional risk. Interview with the RD revealed that a nutritional assessment related to the appropriateness of modified portions was not carried out. [s. 26. (3) 13.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the following for the resident:
1. dental and oral status, including oral hygiene, and
2. nutritional status, including height, weight and any risks relating to nutrition care., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks including vulnerable sector screens are conducted prior to hiring staff members and accepted volunteers who are 18 years of age or older.

Record review for identified staff and volunteers revealed that two accepted volunteers and two staff members were hired between a period of seven months, and did not have the required vulnerable sector screens completed prior to their acceptance/hire date.

Interview with the administrator confirmed that the home's internal hiring practice does not require volunteers to have vulnerable sector screens completed. However, criminal checks are required before they start volunteering in the home; this practice has been in place since February 10, 2012. The administrator confirmed that all staff must have criminal checks including vulnerable sector screens completed before starting work. The administrator also confirmed that the above mentioned volunteers and staff are volunteering/ working in the home, and are waiting for the vulnerable sector screens to be completed. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that criminal reference checks including vulnerable sector screens are conducted prior to hiring the staff member and accepting volunteers who are 18 years of age or older, to be implemented voluntarily.

WN #6: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Record review of the Zero Tolerance of Abuse and Neglect education and training statistics for 2012 and 2013, and administrator's interview revealed that 55 per cent of all staff did not complete the training in 2012, and 74 per cent of all staff did not complete the training in 2013.

The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act includes:
(a) hand hygiene,
(b) modes of infection transmission,
(c) cleaning and disinfection practices, and
(d) use of personal protective equipment.

The manager of infection prevention and control confirmed that 37 per cent of all staff did not complete training on Routine Practices in 2013. [s. 76. (2) 3.]

2. The licensee has failed to ensure that all staff at the home who have received training in relation to the duty under section 24 to make mandatory reports prior to perform their responsibilities, receive retraining annually as required by the regulations.

Section 24 of the Act requires a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff has occurred or may occur to immediately report the suspicion and the information upon which it is based to the Director.

Interviews with three identified registered staff and two identified RAs revealed an unawareness of their duty to make mandatory reports to the Director under section 24 of the Act. Staff interviews revealed that they would report any alleged abuse or neglect to the management, the administrator or the DORC. The management would then report directly to the Ministry.

Record review revealed and interviews with the administrator and DORC confirmed that 51 per cent of all staff did not receive training in the duty to make mandatory reports under section 24 in 2013. [s. 76. (4)]

3. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to mental health issues, including caring for persons with dementia,

Record review and interview with the RCM revealed that 31.25 per cent of all staff who provide direct care to residents did not receive training in mental health issues, including caring for persons with dementia in 2013. [s. 76. (7) 2.]

4. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to behaviour management.

Record review and interview with the RCM revealed that 31.25 per cent of all staff who provide direct care to residents did not receive training in behaviour management in 2013. [s. 76. (7) 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 staff receive the following trainings:
1. the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities,
2. in relation to the duty under section 24 to make mandatory reports prior to perform their responsibilities, receive retraining annually as required by the regulations; and
3. all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to mental health issues, including caring for persons with dementia and behaviour management, and
4. infection prevention and control includes:
(a) hand hygiene,
(b) modes of infection transmission,
(c) cleaning and disinfection practices, and
(d) use of personal protective equipment., to be implemented voluntarily.

WN #7: 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 the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act is fully respected and promoted.

On an identified date, in the dining room of an identified unit, the inspector observed an identified registered staff administering medication. The medication cart was placed at the entrance to the dining room. The identified registered staff left the computer displaying residents' personal health information (PHI) unattended when administering medication to individual residents sitting at the dining tables. The PHI of the residents was easily accessible to anyone passing by.

Interview with the identified registered staff confirmed that the computer should be logged off when he/she left the medication cart unattended. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On an identified date, the inspector observed that the spa room door in an identified unit was ajar, and no staff was in or near the spa room. A pool of water was on the floor between the tub and the spa room door.

Interview with an identified RA confirmed that it is not safe to leave the spa room door open and unattended when there is water on the floor. [s. 5.]

WN #9: 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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On an identified date, on the resident areas of four identified units, the inspector observed that the clean utility rooms were open, and contained oxygen, supplies such as enema kits, drainage bags, and battery back-ups. The door signage read authorized personnel only. In addition, the linen chutes room were unlocked.

Interview with an identified staff in each of these areas confirmed that these doors should be locked.

In addition, on the resident areas of another two identified units, the inspector observed the soiled utility rooms and the laundry rooms to be unlocked.

Interview with an identified RA confirmed that these rooms should be locked. [s. 9. (1) 2.]

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

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident's bed system has been evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

An identified resident's written plan of care indicates two half side rails to be used for emotional security as requested by the family. Interview with an identified staff confirmed that both side rails are up while the identified resident is in bed.

The DORC provided the inspector with a Bed Rail entrapment audit conducted by Shoppers Home HealthCare in October 2011. The audit only indicated 12 resident beds were evaluated, and did not include the identified resident's bed system.

Interview with the DORC confirmed that the October 2011 audit completed by Shoppers Home HealthCare was the most recent evaluation of bed systems in the home, and the identified resident's bed has not been evaluated to minimize risk to the resident. [s. 15. (1) (a)]

2. On an identified date, the inspector observed two quarter bed side rails in the up position while a second identified resident is in bed.

Interview with the identified registered staff confirmed that two quarter side rails are used when the second identified resident is in bed for safety.

Interviews with the RCM and the DORC confirmed that two quarter side rails are used when the second identified resident is in bed for emotional support upon the request of the family.

Record review revealed and interview with the RCM confirmed that the second identified resident was not assessed for the use of bed rails.

Record review revealed and interview with the DOC confirmed that the second identified resident's bed system has not been evaluated to minimize risk to the resident. [s. 15. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

On an identified date, the inspector observed the call bell by the shower in the spa room of an identified unit not functioning and an identified RA was notified.

On six days later, the inspector observed the above mentioned call bell functioning. [s. 17. (1) (b)]

WN #12: 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 immediately report the suspicion and information of abuse of a resident by anyone that resulted in harm or risk of harm, to the Director.

The inspector reviewed the Complaint form of an identified date, from an identified resident's daughter, reporting an allegation of rough handling and lack of willingness to help the resident to the DORC, and all other interview and investigation notes. An investigation was initiated immediately by the home, and discipline rendered to the respective staff.

The inspector reviewed the alleged abuse investigation documentation and it did not include any documented notification of the incident to the Director.

Interviews with the DORC and the administrator confirmed that a Critical Incident was not completed, and they are unable to produce any evidence that the Director was informed immediately of this incident. [s. 24. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered an annual dental assessment.

Interview with the DORC revealed that the most recent annual dental screening was offered to residents in December 2011, by Toronto Public Health. No offer for an annual dental assessment and other preventive dental services has been made thereafter. [s. 34. (1) (c)]

WN #14: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

An identified resident was identified at risk for altered skin integrity and was admitted to hospital for a period of five days.

Record review revealed that a skin assessment was not carried out upon the resident's return from the hospital until three days later.

Interview with the RCM confirmed that a skin assessment is to be carried out upon readmission from the hospital within 24 hours of return. [s. 50. (2) (a)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home.

Record review revealed that an identified resident had a stage 2 pressure ulcer discovered on an identified date, related to the resident’s declining health condition. A review of health record for the identified resident reveals that there is no information regarding an assessment conducted by a RD.

Interview with the RD confirmed that he/she did not assess the resident who had a stage two pressure ulcer. The RD confirmed that a referral for the resident was not received. [s. 50. (2) (b) (iii)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are written approaches to care developed to meet the needs of the residents with responsive behaviours that include:
* screening protocols
* assessment
* reassessment, and
* identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

An identified resident is identified with responsive behaviours.

A record review of the identified resident revealed that responsive behaviours occur frequently during the evenings, particularly after the family's visit which occurs in the evenings.

Interview with the registered staff, RAs and the RCM confirmed that the identified resident's responsive behaviours usually occur in the evenings. The identification of the behavioural triggers that may result in the above mentioned responsive behaviours is not care planned. [s. 53. (1) 1.]

WN #16: 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 respond in writing within 10 days of receiving the Residents' Council concerns or recommendations.

Interview with an identified individual revealed that the home does not respond in writing within 10 days of receiving the Residents' Council concerns or recommendations.

Interviews with the food services supervisor (FSS) and the administrator confirmed that a written response has not been provided within ten days of receiving the Residents' Council concerns or recommendations raised at the Residents' Council meetings for three identified months. [s. 57. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council concerns or recommendations.

Interview with an identified individual revealed that either the administrator / DORC or both attend the first part of the Family Council meetings in sharing information and providing response to concerns raised by the Family Council at the meetings.

Record review revealed that concerns and recommendations were raised at the Family Council meetings on five identified dates.

Interview with the administrator confirmed that the Family Council was not provided with a response in writing within 10 days for the concerns and recommendations raised during the above mentioned identified meetings. [s. 60. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month,
2. A change of 7.5 per cent of body weight, or more, over three months,
3. A change of 10 per cent of body weight, or more, over 6 months,
4. Any other weight change that compromises their health status.

An identified resident was identified at nutritional risk. A referral to the RD was noted on the Quarterly Review Assessment of an identified date, to assess the resident related to the resident's weight, and the ongoing interventions are not effective.

Interview with the RD confirmed that a referral for nutritional assessment for the resident was not received and was not carried out.

A review of the resident's care plan, dated eight days after the above mentioned assessment was conducted, indicates that the goal is to maintain weight at a certain Body Mass Index (BMI) level. Ten days later, the resident's care planned goal was revised in terms of the BMI level. There was no documented nutritional assessment of the resident to support and reflect a change in the goal of the written plan of care.

Interview with the RD confirmed that the resident's BMI was changed without conducting a nutritional assessment. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. A second identified resident was identified as being at nutritional risk. A review of the weight records for the second identified resident reveals a weight change of 10% over 6 months in an identified month, a 7.5% change over 3 months in the month prior, a 10% change over 6 months in the two months prior. In addition, review of the second identified resident's care plan of an identified date during the period of the 10% weight change, indicates that the goal is to maintain the resident's BMI at a certain level. Review of the resident's care plan, dated three months later, indicates that the goal is to maintain the resident's weight above a certain BMI, three levels lower than previous, in the next 3 months. There was no documentation to support and reflect a change in the goal with respect to weight in the written plan of care.

Interview with the RD confirmed that the resident's BMI was changed without conducting a nutritional assessment. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the menu cycle is reviewed by the Residents' Council.

Interviews with the Residents' Council president and the FSS confirmed that the menu cycle has not been presented to and reviewed by the Residents' Council. [s. 71. (1) (f)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Record review and interviews with the administrator and an identified individual confirmed that the advice was not sought from the Residents' Council in developing and carrying out the satisfaction survey in 2013. [s. 85. (3)]

WN #21: 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 was 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.

Interview with the administrator revealed that the appropriate police force were not notified of the alleged abuse of an identified resident, that was reported by the resident's family member on an identified date. Discipline was rendered to the respective staff for rough handling and lack of willingness to help the identified resident.

Upon the inspector's review of the home's alleged abuse investigation notes for the identified resident, no documented notification to the police was found. [s. 98.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's documented record of complaints
(a) is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response.

Record review and interview with the administrator revealed that the home has not developed a process to ensure that the (a) documented record is reviewed and analyzed for trends at least quarterly,(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and (c) a written record is kept of each review and of the improvements made in response. [s. 101. (3)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date on an identified unit, the inspector observed the medication cart to be locked. However, the third drawer of the medication cart was unlocked and open. The cart was unsupervised and there were no registered staff in the area.

Interview with the identified registered staff confirmed that the drawer had not been pushed in all the way and that the fact it was open was an oversight. The registered staff confirmed that it should have been locked. [s. 129. (1) (a)]

2. On another identified date, in the dining room of another identified unit, the inspector observed an identified registered staff administering medication. The medication cart was placed at the entrance to the dining room. The identified registered staff left the medication cart unlocked and unattended when administering medication to individual residents sitting at the dining tables.

Interview with an identified registered staff confirmed that the medication cart should be locked when he/she left the cart and administered medications to residents at the dining tables. [s. 129. (1) (a) (ii)]

3. Four days later, in the dining room of the above mentioned identified unit, the inspector observed another identified registered staff who left the medication cart at the entrance of the dining room unlocked while administering medication to an identified resident at the dining table.

Interview with the identified registered staff confirmed that the medication cart should not be left unlocked when unattended. [s. 129. (1) (a) (ii)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date on an identified unit, the inspector observed an identified medication that was ordered for an identified resident, being administered to a second identified resident.

Interview with an identified registered staff revealed that it was his/her practice to administer the identified medication for all residents from one bottle of the identified medication and when that bottle is finished, to start another resident's bottle of identified medication.

Interview with the DORC confirmed that this practice is not acceptable and also represented a violation of the College of Nurses of Ontario (CNO) standards. The DORC stated that he/she would take immediate action relating to this finding. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of an identified resident's immunization record, revealed that pneumococcal vaccine was not administered to the resident. The identified resident's progress notes of an identified date showed that the resident's family member gave informed consent for the administration of the pneumococcal vaccine. Review of the physician's orders revealed that the physician ordered the vaccine for the identified resident on another identified date, and it was not transcribed by the nursing staff. As a result, the pneumococcal vaccine was not administered to the resident.

Interview with RCM confirmed that the pneumococcal vaccine was not administered to the identified resident as prescribed. [s. 131. (2)]

WN #25: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program as evidenced by:

On an identified date, the inspector observed five unlabeled used deodorant sticks, four unlabeled used toothbrushes, and two unlabeled used razors in the spa room on an identified unit.

Interview with the DORC confirmed that the personal items should be labeled and stored in the residents' designated cupboard in their own bathrooms, not in the spa room. [s. 229. (4)]

2. On another identified date in the afternoon, the inspector observed an identified RA coming out from a resident's room holding a soiled brief with gloves on. The RA then closed the resident's door and opened the chute room on the keypad, placed the soiled brief in the hamper; then took off his/her gloves and placed the gloves in the hamper.

Interview with the identified RA confirmed that he/she had just finished assisting the resident with changing the brief and the gloves should have been taken off prior to leaving the resident's room.

Review of the home's policy titled Personal Protective Equipment (PPE) under the Infection Control Manual, revised June 24, 2014, indicates that PPE, including gloves, are to be removed immediately after the task for which it has been used in a manner that prevents contamination of clothing or skin. [s. 229. (4)]

Issued on this 26th day of September, 2014

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