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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2014	2014_295556_0025	O-000636-14	Resident Quality Inspection

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
2 OVERLEA BLVD., TORONTO, ON, M4H-1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3

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

WENDY PATTERSON (556), JOANNE HENRIE (550), KATHLEEN SMID (161), MEGAN MACPHAIL (551)

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 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 2014

During the course of the inspection, the inspector(s) also completed critical incident inspections for log #'s O-000748-14, O-000567-14, O-000535-14, and O-000609-14

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing and Personal Care (DONPC), Director of Environmental Services (DES), Resident Care Coordinator (RCC), Director Food Services (DFS), Registered Dietitian (RD), Psychiatry Behavioural Support Outreach Nurse (PBSON), Life Enrichment Coordinator, Behavioural Supports Ontario Personal Support Worker (BSO), Residents, Activity Assistants, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers (HSKP), President of the Resident's Council, Chair of the Family Council, and Family Members.

During the course of the inspection, the inspector(s) toured resident care areas, reviewed residents' health care records, reviewed infection control policies, environmental services policies, food services policies, zero tolerance of abuse and neglect policy, medication administration policies, food committee minutes, resident council meeting minutes, family council meeting minutes, infection control meeting minutes, internal incident reports, observed residents meal service, and observed medication administration.

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that two Residents on the home's secure unit were treated with courtesy and respect and in a way that fully recognizes the Residents' individuality and respects the Residents' dignity.

On July 18, 2014 at 09:45 hours, Inspector #161 was working at the nursing station on the secure unit which is home to 26 cognitively impaired residents. Inspector #161 heard RPN #S110 speaking loudly to a Resident in the adjacent dining room stating "eat your muffin". She/he then spelled the word "muffin" and repeated the word "muffin" to the Resident. Inspector #161 left the nursing station and entered into the dining room. Inspector #161 asked RPN #S110 to whom she/he was speaking to regarding the muffin. RPN #S110 indicated that she/he had been speaking to Resident #002 who was observed by Inspector #161 to be walking aimlessly in the dining room. Inspector #161 also observed RPN #S110 perform a diagnostic test on Resident #004 who screamed when the test was performed and proceeded to cry. There were 5 Residents in the dining room at the time of this occurrence.

Inspector #161 discussed both of these observations with the DONPC. In regards to Resident #002, the DONPC indicated that speaking to any Resident in this manner was belittling and disrespectful. She indicated that this constituted verbal abuse. The DONPC also indicated that performing a diagnostic test in the dining room was disrespectful to Resident #004's dignity. The DONPC indicated to Inspector #161 that she took these observations seriously and would deal with these matters immediately. [s. 3. (1) 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 RPN #S110 receives education on the Resident's Bill of Rights and the licensee's Prevention of Abuse policy, to be implemented voluntarily.

WN #2: 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 did not ensure that the home is equipped with a resident-staff communication and response system that can be easily used by residents, staff and visitors at all times.

The home is equipped with a resident-staff communication and response system that Residents activate by pulling on a call bell cord located in their room and in their bathroom.

On July 22, 2014 inspector #161 conducted a random audit of 15 call bells located in resident bathrooms. It was observed that 11/15 of the call bells were not activated when the call bell cords were pulled. Of the call bells audited, 9/15 were tightly attached to the toilet support arm by a plastic zip tie and 2/15 were caught in the hinge of the toilet support arm. It was further observed that there was not a call bell cord in the Rosemount spa shower room.

On July 23, 2014 Inspector #161 discussed these observations with the home's Executive Director who indicated that he would immediately address this issue. The home began rectifying the issue while the inspectors were still in the home. [s. 17. (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 that all call bell cords easily activate the home's resident-staff communication and response system, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of a between meal beverage in the morning.

During stage 1 of the RQI, it was reported that a between-meal beverage is not always offered on Wellington House.

Staff Member #S108 was interviewed and stated that on July 21, 2014 the morning nourishment cart was not circulated to all of the residents on Wellington House. He/she stated that fluid intake is tracked in Point of Care (POC), and that if the resident was not offered a beverage, Not Applicable (NA) would be coded. Staff Member #S115 also stated that coding of NA in POC indicates that the resident was not offered a beverage at the nourishment pass.

A "Fluids - Intake" report for sixteen (16) days for the time frame of July 7-22, 2014 was generated for Residents #012, #016, #017 and #018. For each of these residents, NA is indicated in the AM nourishment row 5/16 days, specifically:

Resident #012: NA is indicated in the AM nourishment row on July 7, 8, 12, 14 and 16, 2014.

Resident #016: NA is indicated in the AM nourishment row on July 7, 8, 12, 14 and 21, 2014.

Resident #017: NA is indicated in the AM nourishment row on July 7, 12, 14, 16 and 21, 2014.

Resident #018: NA is indicated in the AM nourishment row on July 7, 8, 12, 14 and 21, 2014.

These four (4) residents of Wellington House were not offered a between meal beverage in the morning 5/16 days. [s. 71. (3) (b)]

2. The licensee failed to ensure that residents are offered a minimum of a snack in the afternoon.

On Monday, July 21, 2014, Inspector #551 observed the afternoon (PM) nourishment pass on Wellington House.

A copy of the Week 4 - Monday Snack Menu was obtained from the Director of Food Services (DFS). It indicated that along with a choice of beverage at the PM nourishment pass, residents on regular and minced textured diets were to be offered fruit creme cookies or chocolate pudding. Residents on a pureed texture diet were to be offered pureed social tea cookies or chocolate pudding.

The PM nourishment cart was noted to contain hot and cold beverages and regular texture cookies and muffins. There was no chocolate pudding or pureed social tea cookies as specified on the Snack Menu.

Staff Member #S123 who was circulating the nourishment cart was interviewed. She/he was asked what would be served to the residents on minced and pureed texture diets, and replied that they would not be offered a snack and would be offered a beverage only.

According to the Wellington House Diet binder, there are four residents on a puree texture diet and two on a minced texture diet.

The care plans in effect at the time of the inspection for the four residents on a puree texture diet were reviewed. Two residents were assessed as being at high nutritional risk,and all four were assessed as requiring an oral supplement or a fortified food to meet their nutritional needs.

On July 22, 2014 the Director of Food Services was interviewed and stated that the Dietary Aide had reported to her that there was no puree snack option on July 21, 2014 for the PM nourishment pass.

Six residents on texture modified diets were not offered a snack in the afternoon on July 21, 2014 as reported by the Director of Food Services and Staff Member #S123. [s. 71. (3) (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 each resident on Wellington House who is on a regular, minced or puree texture diet is offered a minimum of a snack in the afternoon that follows the Snack Menu rotation; and that each resident on Wellington House is offered a minimum of a between-meal beverage in the morning, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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 failed to ensure that a written record of the annual Infection Prevention and Control program evaluation is kept and includes the following:
* the date of the evaluation
* the names of the persons who participated
* a summary of the changes made, and
* the date those changes were implemented

During an interview on July 24, 2014, the Director of Nursing and Personal Care indicated to Inspector #550 that the Infection Control committee review the Infection Control Program annually but there is no written documentation kept of the evaluation which includes the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented. [s. 229. (2) (e)]

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

On July 22, 2014, Inspector #550 observed residents on contact precautions on two different units. On Queens House a specified room had an isolation cart and a contact precautions sign at the room entrance. On Wellington House five specified rooms had an isolation cart and a contact precaution sign at the room entrance.

On July 22, 2014 staff #S136 indicated to Inspector #550 Resident #024 was no longer on contact precautions. Registered staff #S137 also indicated to Inspector #550 this resident was no longer on contact precautions; that she/he previously had an infection but it was all clear now and they just forgot to remove the contact precaution sign. Inspector #550 reviewed the Resident‘s chart which indicated that the initial infection was all clear but she/he currently had a different infection, and therefore still needed contact precautions in place. Staff #S137 indicated to Inspector #550 she/he was not aware this resident currently had an infection and still needed contact precautions in place, and that no precautions were taken.

During an interview on July 23, 2014, staff #S139 and #S140 who were assigned to resident #024 indicated to Inspector #550 they were not aware this resident required contact precautions although the contact precaution sign was posted on the bedroom door. They both indicated to Inspector #550 that they only wear gloves and no gown when providing care to this resident.

On July 22, 2014 Staff #S102 indicated to Inspector #550 that Resident #025 required contact precautions because of a specified infection. On July 23, 2014 staff #S130 indicated to Inspector #550 she/he should wear gloves and a gown when providing care to this resident as per the contact precaution sign but she/he does not wear a gown when providing care to this resident because no gowns are available in the isolation cart at the room entrance. She/he further indicated to Inspector #550 she/he can get some gowns from the linen cupboard.

On July 22, 2014 Staff #S102 indicated to Inspector #550 that Resident #026 required contact precautions because of a specified infection. Staff #S141 indicated to Inspector #550 she/he wears gloves and gown when providing pericare for this resident; for all other care to this resident she/he wears gloves only.

On July 22, 2014 Staff #S102 indicated to Inspector #550 that Resident #027 required contact precautions because of a specified infection. Staff #S141 indicated to Inspector #550 that she/he wears gloves and a gown when providing pericare for this resident; for all other care to this resident she/he wears gloves only.

On July 22, 2014 Staff #S102 indicated to Inspector #550 that Resident #028 required contact precautions because of a specified infection. Staff #S141 indicated to Inspector #550 she/he was aware of the required contact precautions and wears gloves and a gown when providing pericare for this resident; for all other care to this resident she/he wears gloves only.

On July 22, 2014 Staff #S102 indicated to Inspector #550 that Resident #029 required contact precautions because of a specified infection. Staff #S141 indicated to Inspector #550 she/he was aware of the required contact precautions and wears gloves and a gown when providing pericare for this resident; for all other care to this resident she/he wears gloves only.

During an interview, staff #S141 indicated to Inspector #550 the home's procedure for contact precautions requires staff to wear a gown and gloves for pericare and only gloves for all other care.

During an interview the Director of Nursing and Personal Care (DONPC) indicated to Inspector #550 the home's procedure for contact precautions requires staff to wear gowns and gloves when providing direct care to residents such as pericare, transfers,

dressing, etc. However, they don't have to wear the gown when pushing a wheelchair or feeding a resident.

Inspector #550 reviewed the home's Management of MRSA and VRE policy, revised July 2014. The "Application of Policy" indicated that all residents infected/colonized with MRSA/VRE shall be placed on contact precautions. Inspector #550 also reviewed the home's Additional Infection Control Precautions policy revised February 2014. The "Application of Policy" indicated that initiation of additional precautions must be instituted as soon as symptoms suggestive of infection are noted. The policy states that one of the elements of additional precautions include the use of barrier equipment such as gloves, gowns or masks. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all nursing staff receive education and training on additional precautions to be implemented when dealing with residents with infections; and that all residents with infections are identified to nursing staff on every shift, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

During Stage One of the Resident Quality Inspection (RQI) unlabelled personal care items were observed in several shared bathrooms.

An unlabelled toothbrush was observed on the counter in the shared bathroom of a specified room.

Three identical tooth brushes were observed on the counter in the shared bathroom of a specified room, none of the toothbrushes were labelled.

The shared bathroom in two specified rooms each had an unlabelled comb on the counter.

The shared bathroom in a specified room had an unlabelled toothbrush in an unlabelled drawer.

In an interview PSW #S120 stated that personal items such as toothbrushes, combs, and safety razors are not labelled because they are kept in a labelled drawer in the residents bathroom.

In an interview the DONPC stated that there is no policy in the home regarding labelling of personal items, and personal items such as toothbrushes, combs, and safety razors are not currently being labelled. [s. 37. (1) (a)]

WN #6: 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 failed to seek the advice of the Resident's Council and the Family Council in developing and carrying out the survey, and in acting on its results.

In an interview the President of the Resident's Council stated that in the last 18 months that she/he has been President the home has not sought the advice of the Resident's Council in developing and carrying out the satisfaction survey. The President further stated that a satisfaction survey was recently conducted in the home.

In an interview the Chair of the Family Council stated that he/she has been the Chair of the Family Council since November 2013. The Chair further stated that a satisfaction survey was recently distributed to the residents and the home did not seek the advice of the Family Council prior to conducting the survey.

In an interview the Executive Director stated that the home did not seek advice from the Resident's Council, or the Family Council, in developing and carrying out any of the previous satisfaction surveys. [s. 85. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug that is to be destroyed is a controlled substance, it will be done by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care (DONPC) and a physician or a pharmacist.

Policy #E31 titled "Storage of Medications" revised January 2013 was provided to Inspector #161 by the DONPC. This policy indicates that narcotics that are to be destroyed and disposed of are taken to the DONPC and locked in a secure box until the pharmacy service provider picks them up for destruction.

On July 22, 2014, the DONPC indicated to Inspector #161 that all controlled substances to be destroyed are picked up by the home's pharmacy service provider who takes them back to the pharmacy for destruction. The controlled substances are not destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and a physician or a pharmacist [s. 136. (3) (a)]

2. The Licensee failed to ensure that drugs must be destroyed by a team acting together and composed of, when the drug is not a controlled substance, one member

of the registered nursing staff appointed by the Director of Nursing and Personal Care (DONPC), and one other staff member appointed by the Director of Nursing and Personal Care. For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Policy #E31 titled "Storage of Medications" revised January 2013 was provided to Inspector #161 by the DONPC. This policy indicates that all drugs, other than narcotics, are destroyed by the pharmacy service provider.

On July 22, 2014 discussion held with RPN #S126 who indicated that all drugs that are to be destroyed and disposed of, other than narcotics, are kept in a red sharps container located in the locked medication room. The pharmacy service provider picks up the red sharps container and returns it to the pharmacy for destruction.

On July 22, 2014, the DONPC indicated to Inspector #161 that all drugs, other than narcotics, that are to be destroyed are kept on the units in the locked medication rooms. The home's pharmacy service provider takes these drugs back to the pharmacy for destruction. The drugs are not destroyed by a team composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing and Personal Care. [s. 136. (3) (b)]

Issued on this 22nd day of August, 2014

[redacted]

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