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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2015	2015_288549_0016	O-001972-15	Resident Quality Inspection

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET CORNWALL ON K6J 5V8

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

SANDFIELD PLACE
220 EMMA STREET CORNWALL ON K6J 5V8

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

RENA BOWEN (549), ANANDRAJ NATARAJAN (573), JOANNE HENRIE (550), LINDA HARKINS (126)

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): June 15, 16, 17 ,18 ,19, 22 and 23, 2015

The following logs were inspected during this inspection
O-001159-14
O-001269-14
O-002205-15

During the course of the inspection, the inspector(s) spoke with Family Members, Residents, the President of the Family Council, several Personal Support Workers (PSW), several Registered Nurses (RN), several Registered Practical Nurses (RPN), an Activity Aide, a Housekeeping Aide, the Housekeeping/Laundry Supervisor, the Administrative Assistant, the Director of Care (DOC) and the Administrator. Residential and non-residential areas of the home were toured (including the medication room), several of the home's policies and procedures relating to abuse, fall prevention and management and medication administration were reviewed. Internal investigation documentations, a Critical Incident Report, several resident health care records were also reviewed, observed several meal services and a medication administration pass

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On June 23, 2015 during the medication pass observation, Inspector #550 observed several empty medication packs containing resident's personal health information disposed of in the garbage receptacle attached to the medication cart. Inspector #550 retrieved three empty medication packs which had residents' personal information on them.

During an interview, RPN #102 and RN #113 both indicated to Inspector #550 they are disposing of the empty medication packs in the garbage that is attached to the side of the medication cart, without removing any personal information. The garbage bag is then disposed of with the regular garbage.

The Director of Care indicated to Inspector #550 that registered staff are required to put the empty medication packs in the Stericycle container that is kept in the medication preparation room and pour water over the medication packs to dissolve the personal information.

As such, the home did not protect the resident's right to have his/her personal health information kept confidential. [s. 3. (1) 11. iv.]

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 every resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act, 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 has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

For the purpose of this report, the resident-staff communication and response system is often referred to as the call bell system.

Inspectors #550 and #573 observed there is no resident-staff communication and response system in the TV lounge next to the Terrace dining room as well as in the Courtyard dining room.

Many residents were observed on different days at various times during the day sitting in the TV lounge next to the Terrace dining room watching TV. Residents #002 and #009 indicated to Inspectors #550 and #549 during an interview that there is no call bell system in the TV lounge. They indicated if they need staff assistance when they are in the TV room they have to yell.

The Courtyard dining room is an area that is accessible to residents at all times during the day. PSWs #108 and #109 indicated to Inspector #550 there is no call bell in the Terrace Dining Room. They indicated if they need some assistance, they have to yell or ask another staff member to get them the assistance.

During an interview on June 22, 2015, the Administrator indicated to Inspector #550 there is no call bell in the TV lounge next to the Terrace dining room or in the Courtyard dining room. [s. 17. (1) (e)]

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 resident-staff communication and response system is available in every area accessible by residents specifically the TV lounge next to the Terrace dining room and the Courtyard dining room, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

During the course of the inspection a Critical Incident was reviewed and indicated that on a specific day in May 2015, PSW #106 witnessed PSW #105 slap Resident #016. PSW #106 reported the alleged incident of abuse to the Charge RN #107 on a specific day in May 2015.

Inspector #549 reviewed the home's investigation documentation which indicated that the Charge RN #107 did not immediately report the suspected incident of abuse to the Director on the specific day in May 2015.

The Administrator and the Director of Care were informed of the alleged abuse on a specific day in May 2015 which was two days after the alleged abuse incident occurred. The DOC reported the alleged abuse of Resident #016 immediately to the Ministry of Health and Long Term Care once she became aware of the incident.

The Director of Care confirmed with Inspector #549 that Charge RN #107 received training on the home's Abuse Prevention Policy on a specific day in March 2015 during the orientation program. The Director of Care and the Administrator confirmed that the alleged incident of abuse of Resident #016 was not reported immediately to the Director. (Log# O-002205-15) [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director., to be implemented voluntarily.

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #010 was assessed to be at a moderate risk level for falls as indicated by the home's Fall Risk Assessment Tool (FRAT) which was completed on a specific day in April 2015. Resident #010's current plan of care indicates the resident is at a risk for falls characterized by history of falls/injury, multiple risk factors related to: use of psychotropic medications with a fall risk intervention that "2 sides rails up at all times when in bed for safety".

On June 17 and June 18, 2015 Inspector #549 observed Resident #010 in bed with one ¼ bed rail up on the left side of the bed. On June 18, 2015 RPN #102 indicated to Inspector #549 that the resident has one ¼ bed rail up as the logo at the head of the bed states "one rail up". Inspector #549 also observed the logo over the resident's bed indicating one bed rail up.

On June 18, 2015 at 11:00hrs during a discussion with Inspector #549 and RPN #102, RN #100 indicated that the plan of care for Resident #010 indicates both 1/4 bed rails up at all times when the resident is in bed due to the moderate risk for falls as assessed using the FRAT. RN #100 also indicated that the resident is capable of moving around when in bed which increases the risk of falls and the need for both bed rails to be up. RN #100 indicated that the logo at the head of the resident's bed had not been changed when the resident's plan of care was changed.

During an interview with the DOC on June 18, 2015 it was indicated to Inspector #549 that the expectation is that the bed rail logo over Resident #010's bed match the fall intervention of both bed rails up at all times when the resident is in bed as indicated in the written plan of care to ensure the care set out in the plan is provided to Resident #010.

Inspector #549 observed that both rails were up when Resident #010 was in bed on June 19, 2015 and that the bed rail logo over Resident #010's bed indicated both bed rails up. [s. 6. (7)]

WN #5: 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 steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the inspection Inspector #573 observed a bed system in Room #1 with one bed rail in the up position. The bed rail on the system appeared to the inspector to be an older style bed rail that had large open spaces within the perimeter of the bed rail (the area within the perimeter of the bed rail is known as entrapment zone 1) that did not appear to be consistent with Health Canada's dimensional limitations for entrapment zone 1.

Health Canada, Guidance Document Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, effective date March 17, 2008, published by the Authority of the Ministry of Health states that any open space in entrapment zone 1 of the bed rail should be less than 4 ¾ inches.

Inspector #549 measured the open space within the perimeter of the bed rail and measured a horizontal space , representing the head breath to be 7 inches well in excesses of Health Canada's dimensional maximum of 4 ¾ inches.

Inspector #549 spoke with the Administrator June 19, 2015 regarding the bed systems, specifically the bed rail in room #1. The Administrator indicated that the home had an audit completed by an outside health care equipment company several years ago and thought that all of the bed systems with the old style bed rails had been replace.

An audit of the home's fifty three bed systems was conducted on June 19, 2015 by the home. Of the fifty three bed systems in the home five bed systems were found to have the old style bed rails, room #24, 24, 21, 17 and 1.

The bed system in room #24 and 2 had two old style bed rails attached to the beds however the bed rails were not in use and where removed immediately from the bed systems. The bed system in room #21 had one old style bed rail attached, room #17 had two old style bed rails attached and room #1 had one old style bed rail attached.

On June 19, 2015 at 14:00hrs Inspector #549 observed that all of the old style bed rails were removed from the bed systems in room #24, 24, 21, 17 and 1. The Administrator indicated that all the old style bed rails had been removed from the home and disposed of.

The Administrator indicated to Inspector #549 on June 19, 2015 that five new bed systems will be purchased as part of the home's capital purchase plan for 2015. [s. 15. (1) (b)]

2. On June 16 and 22, 2015, Inspector #573 observed Resident #023's bed system with 2 quarter rails in use. The Resident #023's mattress was short and did not fully fit the deck of the bed frame. Inspector measured the gap to be 7.5 inches between the head board of the bed frame and the end of the mattress (Entrapment Zone 7).

The Health Canada document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" identifies Entrapment Zone 7 as the space between the inside surface of the headboard or foot board and the end of the mattress. No dimensional limit is put forward for Zone 7 although it is identified as potential zone of entrapment.

On June 22, 2015 Inspector #573 observed Resident #023's bed system in the presence of the Administrator who concurred with the inspector that the mattress was too short for the bed frame and also indicated that the present mattress is not compatible with the bed system. The Administrator informed the inspector that she will address the issue immediately and at approximately 13:30 hours the Administrator confirmed with the Inspector #573 that the mattress for that bed system had been changed. [s. 15. (1) (b)]

WN #6: 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 comply with LTCHA ,2007,S.O. 2007, c.8, s 57 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Resident's Council.

The President of Resident's Council indicated during an interview with Inspector #573 that the Council did not receive written response within 10 days from the Licensee regarding any concern or recommendation made by the Council. The President of the Resident's Council further indicated that the concern or recommendations were discussed in the next or subsequent Council meeting.

Inspector #573 reviewed the Resident's Council meeting minutes folder for the month of June 3, 2015. The meeting minutes identified several resident's concerns regarding the cold temperature in the home's small dining room in the morning hours. A written response document dated June 5, 2015 regarding Resident's Council concerns was also attached in the meeting minutes folder.

On June 23, 2015 during an interview with Staff #103 who does the Assistant duties for the Resident's Council indicated to the inspector that any concerns or recommendations from the Resident's Council is documented and sent to the appropriate department. Staff #103 indicated that she will receive the written response from the specific department within 10 days and the written response is communicated to the Resident's council in the subsequent meeting. Staff #103 further stated that the written response document dated June 5, 2015 regarding Resident's Council concerns was not provided to the Resident's Council as of June 23, 2015.

Inspector #573 spoke with the Administrator who indicated that while the home addresses the concerns and recommendations in writing within 10 days the written response is not communicated to the Resident's Council until the next scheduled meeting. [s. 57. (2)]

Issued on this 26th day of June, 2015

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

Original report signed by the inspector.