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
Jan 20, 2015	2014_377502_0015	T-090-14	Resident Quality Inspection

Licensee/Titulaire de permis

NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET NORTH YORK ON M2K 1E1

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

SENIORS' HEALTH CENTRE
2 BUCHAN COURT NORTH YORK ON M2J 5A3

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

JULIENNE NGONLOGA (502), SUSAN SQUIRES (109), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 24, 25, December 8, 9, 10, 23, 29, 30, and 31, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, director of care (DOC), assistant director of care (ADOC), registered nurses (RN), registered practical nurse (RPN), personal support workers (PSW), registered dietitian (RD), food service manager (FSM), environment service manager (ESM), dietary aides (DA), activity aide, physiotherapy aide (PTA), residents, family members and substitute decision makers.

The inspectors also toured the resident home areas, observed medication administration, resident to staff interactions, resident to resident interactions, provision of care, reviewed clinical and home records and related home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **1 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 O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall 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; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene and the use of personal protective equipment (PPE).

Review of the staff personal protective equipment (PPE) and hand hygiene's training records revealed that 68.5 per cent of staff had not been trained on hand hygiene in 2013, and that 77.9 per cent of staff had not been trained as of December 30, 2014. Furthermore 62.1 per cent of staff had not been trained on the use of PPE in 2013, and that 12.8 per cent of staff had not been trained as of December 30, 2014.

This was confirmed by an identified management staff member. [s. 219. (4) (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 the retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene and the use of personal protective equipment, to be implemented voluntarily.

WN #2: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 the stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, or doors that residents do not have access to are kept closed and locked, and equipped with a door access control system that is kept on at all times.

On November 24, 2014, at 11:00 a.m. the inspector observed that Stairwell #3's door on the second floor was closed but not locked. The door was not connected to the mag locks, despite a sign requiring the use of stairs code to access the stairwell. The inspector immediately brought this to the Administrator's attention. The Administrator tested the door and confirmed that the unlocked stairwell's door was accessible to residents and it should be kept locked at all times. The Administrator then proceeded to reset the door. [s. 9. (1) 1.]

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

On December 8, 2014, the inspector observed the spa room on the first floor east side to be unlocked with no staff in the surrounding area.

Interviews with identified staff members on the first floor confirmed that the spa room's door is unlocked and indicated that the spa room door's key was not available and accessible to staff. Interview with the Administrator revealed that he/she was unaware that the spa room door on the first floor east side was unable to be locked. [s. 9. (1) 2.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On December 9 and 31, 2014, the inspector observed deep scratches and chipped paint on the walls in the dining room on the first floor .

Interview with the environmental services manager confirmed that the walls in the dining room on the first floor are not in a good state of repair and the home is in the process of repainting all dining rooms. [s. 15. (2) (c)]

WN #4: 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 November 24, 2014, the call bells were observed to be non-functioning on three occasions.
- the call bell in the shower room on the first floor west ,
- the call bell in the shower room on the second floor west , and
- the call bell near the toilet in the shower on the third floor east.

Interview with the identified staff indicated that the call bells should be working. This was brought to the Administrator's attention who confirmed that the call bells should be functioning at all times. [s. 17. (1)]

WN #5: 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. (1) A Residents' Council of a long-term care home has the power to do any or all of the following:
1. Advise residents respecting their rights and obligations under this Act. 2007, c. 8, s. 57 (1), 195 (4,5).
3. Attempt to resolve disputes between the licensee and residents. 2007, c. 8, s. 57 (1), 195 (4,5).
4. Sponsor and plan activities for residents. 2007, c. 8, s. 57 (1), 195 (4,5).
5. Collaborate with community groups and volunteers concerning activities for residents. 2007, c. 8, s. 57 (1), 195 (4,5).
6. Advise the licensee of any concerns or recommendations the Council has about the operation of the home. 2007, c. 8, s. 57 (1), 195 (4,5).
7. Provide advice and recommendations to the licensee regarding what the residents would like to see done to improve care or the quality of life in the home. 2007, c. 8, s. 57 (1), 195 (4,5).
8. Report to the Director any concerns and recommendations that in the Council's opinion ought to be brought to the Director's attention. 2007, c. 8, s. 57 (1), 195 (4,5).
9. Review,

i. inspection reports and summaries received under section 149,
ii. the detailed allocation, by the licensee, of funding under this Act and the Local Health System Integration Act, 2006 and amounts paid by residents,
iii. the financial statements relating to the home filed with the Director under the regulations or provided to a local health integration network, and
iv. the operation of the home. 2007, c. 8, s. 57 (1), 195 (4,5).
9. Review,
i. inspection reports and summaries received under section 149,
ii. the detailed allocation, by the licensee, of funding under this Act and the Local Health System Integration Act, 2006 and amounts paid by residents,
iii. the financial statements relating to the home filed with the Director under the regulations or provided to a local health integration network, and
iv. the operation of the home. 2007, c. 8, s. 57 (1), 195 (4,5).
10. Exercise any other powers provided for in the regulations. 2007, c. 8, s. 57 (1), 195 (4,5).

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 promote the power of the Residents' Council to review the detailed allocation, by the licensee, of funding under the Act and the Local Health System Integration Act, 2006 and amounts paid by residents, and the financial statements relating to the home filed with the Director under the regulations or provided to a Local Health Integration Network.

Interview of the Residents' Council and review of council's minutes revealed that the Residents' Council requested to review the above identified documents in August, September and October 2014. The licensee has not provided this information to the council as of December 30, 2014.

This was confirmed by the home's administrator. [s. 57. (1) 9.]

2. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advise related to concerns or recommendations.

Record review and resident interview revealed that residents raised concerns in the October 2014, Residents' Council meeting about staff not arriving in the dining room in a timely manner and staff were leaving the dining room before the meal was finished. The Residents' Council also voiced concerns about dirty towels being left on the floors of the bathing rooms.

There was no written response to the council. According to the DOC, the response that was made did not get circulated to the council. [s. 57. (2)]

WN #6: 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.

Record review indicated that resident #05 had an involuntary weight loss as follow:
- 9.3 per cent of body weight loss over one month on July 2, 2014,
- 16.1 per cent of body weight loss over three months on September 5, 2014, and
- 15.9 per cent of body weight loss over six months on December 6, 2014.

Record review revealed and nterview with the RD and nursing staff confirmed that resident #05 was not referred to the RD after he/she lost weight in July and December 2014. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #7: 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 that the home's menu cycle is reviewed by the Residents' Council for the home.

Resident interview revealed that the residents wanted a new menu for fall and winter 2014. A review of the food committee minutes dated May 27, 2014, indicated that the home's specific menu items were to be kept for two additional years while the home remains in the process of implementing Synergy on demand.

Staff interview confirmed that the residents have expressed concerns about the corporate menu and they requested to have a new menu specific to home. The staff member informed the residents that developing a new menu was not possible due to limited time prior to the menu roll-out. He/she suggested that the menu implemented for fall and winter in 2013, be implemented again on November 10, 2014, for fall and winter 2014-2015, and the residents will review the menu after the roll-out. The staff member also confirmed that the residents were informed, but he/she failed to give the council the menu to review before rolling out the menu for fall and winter 2014-2015. [s. 71. (1) (f)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff comply with the cleaning schedule for all equipment related to dining and snack areas.

The cleaning schedule for the dining area on the first floor directs staff to clean the microwave daily. On December 9, 2014, the microwave in the servery on the first floor was observed soiled with dried food debris.

A review of the signed off cleaning schedule revealed that the microwave was not cleaned on December 6, 7, and 8, 2014. An identified staff confirmed that the microwave was not clean during the weekend of December 7, 2014. [s. 72. (7) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that sufficient time is provided for residents to eat at their own pace.

On December 9, 2014, resident #12 was observed being rushed by an identified staff. The staff member was standing by the resident right side while feeding the resident without giving sufficient time to swallow. The staff member acknowledged rushing resident #12, and he/she then sat down and continued to feed the resident slowly. [s. 73. (1) 7.]

2. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

Observations made on various occasions revealed that the residents were served two courses at the same time.
On December 8, 2014, during lunch service on the first floor dining room, residents #14 and #15 were observed to be served entrée while they were eating their soup.
On December 9, 2014, during lunch service on the fourth floor dining room residents #16, #17, and #18 were observed to be served desert while they were eating entrée.
On December 29, 2014, during lunch service on the first floor dining room residents sitting on table #4, #5, #6, #7 and #8 were observed to be served desert while eating the entrée.

Interviews with identified staff confirmed that the meal was not served course by course during lunch service. [s. 73. (1) 8.]

3. The licensee has failed to ensure that there are appropriate furnishings and equipment in resident dining areas, including tables at an appropriate height to meet the needs of all residents.

On December 8 and 9, 2014, resident #01 and #11, were observed sitting low in the wheelchair at the dining room table while they were eating lunch. Their shoulders were aligned with with the height of the dining room table.

Interviews with identified staff confirmed that the dining room tables were not at the appropriate height to meet resident #01 's and #11's needs. [s. 73. (1) 11.]

4. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

On December 30, 2014, resident #13 was observed to be served soup at 12:03 p.m., when staff was not available to assist the resident. The inspector brought that to an identified staff member's attention at 12:12 p.m., the staff confirmed that he/she was not available when the food was served because he/she was looking for a feeding stool to assist the resident. [s. 73. (2) (b)]

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

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

On December 9, 2014, a tooth brush and two hair brushes were observed without a label in a shared bathroom . An identified staff confirmed that the items were not labelled and proceeded to label them. [s. 229. (4)]

Issued on this 21st day of January, 2015

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

Original report signed by the inspector.