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 26, 2015	2014_235507_0023	T-098-14	Resident Quality Inspection

Licensee/Titulaire de permis

DON MILLS FOUNDATION FOR SENIORS
1 Overland Drive TORONTO ON M3C 2C3

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

THOMPSON HOUSE
1 OVERLAND DRIVE NORTH YORK ON M3C 2C3

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

STELLA NG (507), JOANNE ZAHUR (589), MATTHEW CHIU (565)

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): December 18, 22, 23, 24, 29, 30 & 31, 2014, January 2, 5 & 6, 2015.

The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T- 308-13 and T-349-13.

During the course of the inspection, the inspector(s) spoke with president & chief executive officer (P&CEO), director of nursing (DON), clinical coordinator (CC), registered staff, personal support workers (PSWs), physiotherapist (PT), program manager (PM), recreationist, registered dietitian (RD), food services director, environmental services supervisor (ESS), residents, family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

a) Interview with the physiotherapist (PT) revealed that modes of transfer category which includes the use of bed rails under section G of the Minimum Data Set (MDS) assessment is completed by the PT for all residents. However, the PT is only responsible for developing the written plan of care for those residents who receive physiotherapy service during the observation period.

Review of the MDS assessment on an identified date, indicated that an identified resident uses bed rails for bed mobility and transfer. The written plan of care on an identified date, indicated that the resident requires bed rails when in bed for safety.

Record review revealed and interview with the PT confirmed that the identified resident was not receiving physiotherapy service when the above mentioned MDS assessment was being completed and the above mentioned written plan of care was being developed.

Interviews with the PT and an identified registered staff confirmed that the PT and the nursing staff did not collaborate with each other in the development and implementation

of the plan of care for the identified resident in relation to the use of bed rails.

b) Review of the MDS assessment on an identified date, indicated that another identified resident uses bed rails for bed mobility and transfer, and the use of bed rails is not included in the resident's written plan of care.

Interview with an identified personal support worker (PSW) revealed that the use of bed rails for the identified resident is for safety. Interviews with the identified resident, and an identified registered staff revealed that the resident uses the bed rails for bed mobility and transfer. Interview with the identified registered staff confirmed that staff did not collaborate with each other in the development and implementation of the plan of care for the identified resident in relation to the use of side rails.

c) Review of the MDS assessment on an identified date, indicated that an identified resident's vision is impaired. The resident can see large print, but not regular print in newspaper or books. The resident's impaired vision is not included in the resident's written plan of care.

Interview with an identified registered staff confirmed that the staff and others involved in the different aspects of care of the identified resident did not collaborate with each other in the development and implementation of the plan of care in relation to the resident's impaired vision.

d) Record review revealed that another identified resident's vision is impaired, and interviews with an identified PSW and an identified registered staff confirmed that the resident requires assistance for choosing his/her clothes from the closet due to impaired vision.

Record review revealed that the above mentioned intervention is not included in the identified resident's written plan of care. Interview with the identified registered staff confirmed that the staff and others involved in the different aspects of care of the identified resident did not collaborate with each other in the development and implementation of the plan of care in relation to the resident's impaired vision. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Review of an identified resident's MDS assessment on an identified date indicated that the resident's vision is impaired. He/she sees large print, but not regular print in newspapers or books, and does not wear glasses, contact lenses or uses a magnifying glass. Review of the resident's written plan of care on an identified date indicated that interventions for the resident's impaired vision include the following:
• adapt resident's room to meet the needs to recognize objects in the resident's own room,
• avoid glare coming in from the window,
• resident does not wear eye glasses,
• position window blinds to decrease glare, and
• use large print materials with resident.

Interview with an identified PSW confirmed that he/she is aware of the identified resident's impaired vision. However, he/she is not aware of the above mentioned interventions. In addition, the identified PSW confirmed that the first time he/she reviewed the resident's written plan of care in relation to the impaired vision was on the day when the inspector brought this to his/her attention. [s. 6. (8)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
1. the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement with each other, and
2. the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #2: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training and retraining in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act annually.

Record review revealed and interview with the clinical coordinator (CC) confirmed that not all staff received training in infection prevention and control in 2014. [s. 76. (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 staff receive training and retraining in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act annually, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

Record review revealed and interview with the CC confirmed that not all direct care staff received training in falls prevention in 2014. [s. 221. (1) 1.]

2. The licensee has failed to ensure that all staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents.

Record review and interview with the CC confirmed that not all staff who provide direct care to residents received training in skin and wound care in 2014. [s. 221. (1) 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 direct care staff are provided training in falls prevention and management, and skin and wound care, to be implemented voluntarily.

WN #4: 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 of having his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act.

On an identified date, the inspector observed an identified registered staff leaving the medication cart unattended on three occasions during the medication pass, with the computer screen displaying an identified resident's personal health information (PHI).

Interview with the identified registered staff confirmed that when the medication cart is left unattended, the computer screen is to be logged off. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian (RD) 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.

The home's policy titled "Skin Care and Pressure Ulcer Management", reference #N004-004, dated May 2014, indicates that residents who have stage II pressure ulcers are to be referred to the registered dietitian (RD) for nutritional assessment. This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: 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 entrapment, taking into consideration all potential zones of entrapment.

On an identified date, the inspector observed one quarter bed rail on the left side of an identified resident's bed in the up position, and the resident was not in bed.

Interviews with the resident, an identified PSW and an identified registered staff confirmed that two bed rails are used for bed mobility and transfer when the resident is in bed.

Record review of entrapment report completed by Therapeutic Services Solution (TSS) dated August 6, 2014, indicated that the identified resident's bed failed the entrapment zone 1. The recommendation to replace or remove rails failing zone 1 was made.

Interview with the director of nursing (DON) confirmed that the above mentioned intervention was not completed to prevent entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

WN #7: 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 clearly indicates when activated where the signal is coming from.

On an identified date, the inspector observed the call bell for an identified resident was not working and it did not indicate any signal (visual or auditory) when activated. The inspector informed an identified registered staff and he/she indicated that he/she was not aware of this and he/she would inform the maintenance staff to fix it.

Two days later, the inspector observed the above mentioned call bell not functioning, and an identified registered staff was notified. [s. 17. (1) (f)]

WN #8: 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 each resident of the home receives 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.

Record review revealed and interviews with an identified registered staff and the CC confirmed that an identified resident was not offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker (SDM) as required by the Regulation. [s. 34. (1) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

A review of an identified resident's health record revealed that the resident had a fall on an identified date, and a post fall assessment was not completed using a clinically appropriate assessment instrument specifically designed for falls.

A review of another identified resident's health record revealed that the resident had a fall on an identified date, and a post fall assessment was not completed using a clinically appropriate assessment instrument specifically designed for falls.

Interviews with two identified registered staff, the DON and the CC confirmed that post-fall assessments were not completed for the two identified residents using a clinically appropriate post-fall assessment instrument. [s. 49. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee 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, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Record review revealed that a wound on an identified resident's limb was documented on an identified date. The wound was documented as a stage 2 ulcer three months later.

Record review revealed and interviews with an identified registered staff and the RD confirmed that a referral to the RD was not made in relation to the identified resident's ulcer until it was documented as a stage 2 ulcer. A nutritional assessment by the RD was not completed until then. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review revealed that a wound on an identified resident's limb was documented on an identified date. The wound was documented as stage 2 and stage 3 ulcers three and four months later respectively.

Record review revealed and interview with an identified registered staff confirmed that the weekly skin assessment using the "weekly wound assessment record" on the Point Click Care (PCC) for the resident's ulcer did not start until four months after the documentaton of the wound. [s. 50. (2) (b) (iv)]

WN #11: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complaint.

Review of the home's complaints and responses record revealed and interview with the president & CEO confirmed that the home received two complaints from two identified residents on an identified date, regarding the operation of the home. The home did not document the dates on which the responses were provided to the complainants and a description of the response. [s. 101. (2)]

WN #12: 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. (6) 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. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On an identified date, the inspector observed a container with surplus medications in pouches in an identified medication room. Interview with the CC revealed that when a surplus drug is destroyed it is not denatured.

An interview with the DON and the CC confirmed that it is not the home's practice to denature a drug once destroyed. [s. 136. (6)]

WN #13: 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 has failed to ensure that a written record is kept relating to each evaluation of the infection prevention and control program that includes the date of the evaluation and the names of the persons who participated in the evaluation.

Record review revealed and interview with the CC confirmed that the evaluation of the infection prevention and control program was conducted informally, and the home did not keep a written record relating to each evaluation that includes the date of the evaluation and the names of the persons who participated in the evaluation. [s. 229. (2) (e)]

2. The licensee has failed to ensure that all staff participate in the implementation of the program.

On an identified date, the inspector observed an identified PSW assisting two residents with their lunches in the dining room. While assisting the two identified residents, the identified PSW went to the next table and cleaned up the spilled fluid. The PSW returned to assist the residents with their lunches without washing his/her hands.

On another identified date, the inspector observed an identified PSW pushing a resident in the wheelchair with disposable gloves on. Interview with the identified PSW revealed that he/she had the gloves on because he/she had provided care to the resident prior to transporting the resident. The identified PSW confirmed that he/she should take the gloves off prior to transporting the resident, and he/she did not do so.

Review of the home's policy titled "Hand Hygiene", reference #IC-0602-00, dated January 2013, indicates that staff are to wash hands before preparing, handling or serving food.

Interview with the CC confirmed that staff are not supposed to wear gloves while transporting residents. [s. 229. (4)]

Issued on this 3rd day of February, 2015

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

Original report signed by the inspector.