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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Dec 16, 2016	2016_420643_0012	033670-16	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

ADAM DICKEY (643), STELLA NG (507)

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 2, 5, 7, 8, 9, 12, 13, and 14, 2016

The following complaint was inspected concurrently with the Resident Quality Inspection: Log #027633-15 related to safe and secure home.

During the course of the inspection, the inspector(s) spoke with the President and CEO, Director of Nursing (DON), Registered Nurses (RN), Personal Support Workers (PSW), Student PSW, Registered Dietitian (RD), Dietary Supervisor, Registered Physiotherapist (PT), Laundry Aide, residents, Substitute Decision Makers (SDM), and Residents' Council Representative.

During the course of this inspection, the inspectors conducted a tour of the home; observed meal service, medication administration, staff to resident interactions and the provision of care, and reviewed resident health care records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

Review of a Critical Incident Report (CIR) submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home revealed that on an identified date, at an identified time, resident #020 was found on the floor lying on his/her side in a shower room on an identified resident home area.

Review of the progress notes and interview with RN #114 revealed that resident #020 had been offered a scheduled shower on an identified date but declined. At an identified time staff members heard noise coming from the shower room and found the resident on the floor. The resident had already showered him/herself and had lost his/her balance and fell while trying to put his/her pants on, sustaining an identified injury.

Review of resident #020's written plan of care, revealed that the resident ambulated independently, and required minimal assistance for bathing for safety. One person was to walk with the resident to the shower room and ensure the resident sat safely in the shower chair. The expected outcome was to bathe safely and appropriately with staff present in the shower room.

Interviews with PSWs #104 and 110, and RN #114 revealed that on an identified date, staff were unaware the identified shower room door was open, despite expectation from the home that it be locked when not in use. In addition, staff #104, 110 and 114 revealed staff were not aware that resident #020 entered the shower room and showered him/herself until they found him/her lying on the floor in the shower room.

On an identified date, the inspector observed that a shower room door was ajar and no residents or staff were in the immediate vicinity. A note reading "This door must be kept locked" was posted on the door.

Interviews with PSWs #104, 107, 110, 112 and 113, RN #105 who were on duty on the identified resident home area, revealed that they were not aware that the shower room door was open despite all of them having been aware that the shower room door was to be closed and locked when not in use.

Interview with the DON revealed that a key lock had been in place on the shower room door on the identified resident home area at the time resident #020's fall incident occurred on the identified date. The DON further stated that the key lock was not effective and resident #020 was able to gain access to the shower room by him/herself. The DON confirmed that an automatic lock was installed on the identified shower room door after the above mentioned incident and the expectation of the home was that staff ensure the shower room door was locked when not in use. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

During stage one of the Resident Quality Inspection (RQI), resident #006 was triggered for inspection related to minimizing of restraining.

Review of the home's policy titled "Minimizing of Restraints" (reference #N007-004, effective February 2014), indicated when a PASD is used, the resident's care plan must indicate how, when and why the device is to be used as a support to promote independence and quality of life. The care plan must indicate the removal of the device as soon as no longer needed to promote independence.

During observations on two identified dates, resident #006 was seated in a tilt wheelchair tilted at approximately 20 degrees.

Review of the resident #002's most recent written plan of care failed to reveal the use of a tilted wheelchair.

Interviews with PSW #104 and RN #105 on an identified date, revealed that the purpose of tilting the wheelchair for resident #006 was to promote comfort, proper posture and relaxation. RN #105 confirmed that the use of the tilted wheelchair as a PASD should have been included in the resident's plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

a) During stage one of the RQI, resident #006 was triggered for inspection related to minimizing of restraining.

During observations on two identified dates resident #006 was noted in a tilt wheelchair tilted approximately 20 degrees.

Review of the home's policy titled "Minimizing of Restraints" (reference #N007-004, effective February 2014), indicated when a resident required the use of a PASD, the following procedure is included:

Discuss with the resident/ SDM:
- Goals for use of the PASD
- Measurable objectives related to support for daily living activity
- Period of day when the PASD is required
- Frequency that resident will use it
- Deadline date for re-evaluation of the need for the PASD

- Alternatives to the PASD
- Obtain and record informed consent (including the risks and benefits of alternative treatment options and risks and benefits to use of the PASD have been outlined to the resident/SDM.

Record review of resident #006's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment from an identified date, revealed that the resident's cognitive skills for daily decision-making were impaired. Review of the resident's health records failed to reveal consent from the SDM in regards to the use of a tilted wheelchair.

Interview with the PT confirmed that consent was not obtained as required under the Act when the resident was assessed for use of a tilted wheelchair as a PASD.

b) During stage one of the RQI, resident #004 was triggered for inspection related to minimizing of restraining.

During observations on two identified dates, resident #004 was noted in a tilt wheelchair tilted approximately 30 degrees.

Record review of resident #004's RAI-MDS assessment from an identified date, revealed that the resident's cognitive skills for daily decision-making were impaired. Review of the resident's health records failed to reveal consent from the SDM in regards to the use of a tilted wheelchair.

Interview with the PT confirmed that consent was not obtained as required under the Act when the resident was assessed for the use of a tilted wheelchair as a PASD. [s. 33. (4) 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 a Personal Assistance Services Device (PASD) is used to assist a resident with a routine activity of daily living only if the use of the PASD is included in the resident's plan of care and that the use of the PASD has been consented to by the resident, or if the resident is incapable, a substitute decision maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #3: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

On an identified date, the inspector observed the shower room door on the west wing of third floor was open, and resident #002 was being assisted with a shower. The inspector observed that the resident did not have any clothes on, except a bath towel covering his/her pelvis area.

Interview with resident #002 on the same day revealed that he/she was not aware that the shower room door had been open while being assisted with a shower that day.

Interviews with student PSW #118 and PSW #119 revealed that resident #002 had been incontinent prior to the shower. While student PSW #118 assisted the resident with the shower, PSW #119 left the shower room to sanitize resident #002's mobility device and had forgotten to close the shower room door.

Interviews with RN #114 and the DON confirmed that every resident's privacy and dignity should be respected, and leaving the shower room door open while assisting a resident with showering was not acceptable. [s. 3. (1) 8.]

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident and the needs and preferences of that resident.

On an identified date, during stage one of the RQI, resident #002 told the inspector that he/she would prefer to have a sponge/ bed bath at times, and did not like showers as he/she was always cold when showered. Resident #002 stated that he/she would prefer to have a choice regarding bathing. In a subsequent interview with resident #002 six days later, he/she stated that the staff had been aware that he/she does not like to have a shower.

Record review of resident #002's written plan of care indicated that he/she was to be showered by one staff member twice per week. Resident #002's written plan of care further stated that he/she preferred showers.

In an interview with RN #105, he/she stated that he/she was aware that resident #002 did not like showers, and preferred to have a sponge bath. RN #105 further stated that resident #002 would be encouraged to have a shower at least once per week as he/she was incontinent.

In an interview with the DON he/she confirmed that resident #002's written plan of care should have included his/her preference for a sponge/bed bath. The DON agreed that in this case the licensee had failed to ensure that the care set out in the plan of care was based on an assessment resident #002 and the needs and preferences of the resident. [s. 6. (2)]

Issued on this 16th day of December, 2016

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

Original report signed by the inspector.