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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 3, 2017	2017_606563_0010	015287-16, 025039-16, 029580-16, 031319-16	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

Berkshire Care Centre
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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

MELANIE NORTHEY (563), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 12, 13, 14, 15 and 16, 2017

The following intakes were completed during the course of this inspection:
029580-16 - IL-47092-LO related to improper care
031319-16 - IL-47683-LO related to alleged resident abuse resulting in a fall
015287-16 - IL-44669-LO related to alleged improper care and abuse
025039-16 - IL-45915-LO related to maintenance issues

PLEASE NOTE:
Written Notification (WN) #1 and Voluntary Plan of Correction (VPC) under LTCHA, 2007,S.O. 2007,c.8 s. 6 (9)1, identified in concurrent inspection #2017_606563_0011 will be issued in this report.
WN #3 and VPC under LTCHA, 2007,S.O. 2007,c.8 s. 19 (1), identified in concurrent inspection #2017_606563_0011 will be issued in this report.
WN #4 and VPC under LTCHA, 2007,S.O. 2007,c.8 s. 24 (1), identified in concurrent inspection #2017_606563_0011 will be issued in this report.
WN #5 and VPC under O. Reg 79/10 s. 49 (2), identified in concurrent inspection #2017_606563_0011 will be issued in this report.
WN #7 under O. Reg 79/10 s. 99, identified in concurrent inspection #2017_606563_0011 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Quality Improvement Educator, the Environmental Service Manager, a Housekeeper, Registered Practical Nurses, Personal Support Workers, family members and residents.

The inspector(s) also made observations of residents and care provided. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **7 WN(s)**
- **7 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A) Review of the Critical Incident (CI) System report #2541-000010-17 stated the resident had a fall with an injury.

The Responsive Health Management 2004 "Assessment of a Fall" policy last revised March 2014 stated to initiate the head injury routine immediately and follow the head injury routine protocol if there was evidence of a head injury.

The Neurological Flow Sheet had vital signs and neurological checks missing during the required time frame. (563)

B) Review of the complaint information report # IL-47683-LO where the complainant voiced concerns to the Ministry of Health and Long Term Care (MOHLTC) related to a fall for the resident. Review of the CI System report #2541-000037-16 stated the resident sustained an unwitnessed fall with an injury.

The Neurological Flow Sheet should have included the level of consciousness, movement, hand grasps, pupillary size and reaction, verbal response and vital signs, but there was no evidence of this.

The Director of Care (DOC) acknowledged that the expectation was that staff complete the neurological flow sheet in accordance with the policy for Head Injury Routine and that all elements were to be documented.

The licensee has failed to ensure that the provision of the care set out in the plan of care related to head injury routine was documented.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There is no compliance history of this legislation being issued in the home in the past three years. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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, furnishings and equipment were kept clean and sanitary and were maintained in a safe condition and in a good state of repair.

Complaint information report # IL-45915-LO was submitted to the MOHLTC and stated there was water damage and the building was very run down. The complainant had specific housekeeping and disrepair issues related to a specific floor.

The specific home care area was observed to have multiple areas of disrepair along doorways with chipped paint, and buildup of dirt and dust along floors in resident rooms, bathrooms and hallways. The walls were chipped with streaked black marks in all home areas and brick walls were observed splattered with brown dried fluids with a buildup of dust and dirt at the baseboards. There were multiple areas where baseboards were peeling and collecting dirt, dust and debris. The ventilation above the double doors had black dust spread across the ceiling with a hole to the right of the vent. One resident was sitting in a manual wheelchair and the resident's medical equipment was covered in

layered dirt and dried food.

In all care areas the floors had a buildup of dirt and debris along the floor perimeter with disrepair and peeled cracked baseboards. Baseboards in disrepair exposed a protruding hard edge at doorways. Hand rails were chipped, rough, and marked with black streaks. There were multiple areas of disrepair along doorways where chipped paint was observed, a buildup of dirt and dust along floors in resident rooms and bathrooms, and the paint was streaked with black marks along the white painted brick walls and there was evidence of dried fluids. Most entrance door frames to the tub/shower rooms had significant dry wall disrepair at the corners.

The Director of Care (DOC) was shown the Blackberry pictures of the disrepair and of the dried buildup of dirt and food on a resident's medical equipment. The DOC shared that all medical devises and supplies were to be cleaned by the registered nursing staff and verified that the resident's medical equipment was not kept clean and sanitary. The DOC also acknowledged that there were multiple areas in the home that were in disrepair.

The Marquise Hospitality "Floor care and Maintenance: Refinishing of Various Floor Types" policy index ID: ES C-15-40 last revised January 21, 2015 stated, "To protect floors from spills and stains and ensure floors are easily maintained." "To maintain all floors in a clean and sanitary condition with a protective finish."

The housekeeper shared that the build-up along the floor edge along baseboards and doorways was almost impossible to remove because it was wax on top of dirt layered over many years. The housekeeper shared that dry sweeping the floors in common areas, resident rooms and hallways occurred every day. Wet mopping of the dining room after meals, resident rooms and bathrooms occurred daily and spot cleaning of hallway floors if there was a spill. Otherwise, the halls were done on the evening shift with the machine. Also, walls were cleaned with spot washing as needed, but once a month at the end of every month the walls were washed. Each housekeeper was responsible for deep cleaning two resident rooms every day on each floor and each housekeeper was responsible for daily routines on two resident floors. The housekeeper shared that the floors were not easily maintained.

The Marquise Hospitality "Floor Care and Maintenance: Stripping and Refinishing Floors" policy index ID: ES C-15-20 last revised January 21, 2015 stated the purpose was "to remove the floor sealer when it no longer responds to mopping, spray buffing and re-

waxing, when the finish begins to build up along the edges or starts to turn colour. To maintain clean, attractive floors and to protect floor surfaces. To maintain a clean and pleasant looking environment, requiring minimal maintenance." The policy documented that “stripping should not be required more often than once every three (3) years and in between, floors should be wet scrubbed once every 6-18 months.”

The Marquise Hospitality "Floor Care and Maintenance: Wet Scrubbing and Refinishing Floors" policy index ID: ES C-15-30 last revised January 21, 2015 stated the purpose was, "to remove heavy deposits of dirt and soil-impregnated surfaces of floor finishes which cannot be easily cleaned with damp and wet mopping."

The Environmental Service Manager (ESM) shared the home used a Maintenance Care software by all staff to create a work order, the request automatically alerts the ESM's and the maintenance staff member's iPod and cell phone in real time. Once the issue was resolved the work order was closed and reports can then be reviewed and analyzed by management and the maintenance staff. The ESM shared there was a running tally of the work due and it was prioritized every morning at the start of the day. The ESM also shared that a formal audit was done quarterly and an excel spreadsheet document was created by the auditor for maintenance staff to follow. The audit acted as a guide for repairs and housekeeping that needed to be completed. The ESM stated the brick surface of the walls was course and almost impossible to clean, and housekeepers need to scrape the build-up. Inspector asked about the resident room door frames where layered multi-coloured paint was present due to chipping. The ESM shared that painting does not make the priority list and on some home floors the paint would be chipped within days due to wheelchairs and lifts. Discussed the dirt build up along floors, baseboards and doorways and the ESM shared it has been there for years, the build-up of dirt and wax was layered and impossible to remove without mechanical stripping of the floors; but the entire building floors, once a year in November, were deep cleaned with a heavy buffing pad.

By telephone, the ESM shared that in reviewing the maintenance and housekeeping audit dated March 22, 2017, the ESM did not have a specific understanding of the audit system responses by the auditor. The ESM verified that the audit was vague, and did not identify specific concerns related to the disrepair of baseboards in the corridors. The ESM also shared that the stripping and refinishing of the floors has not been done in the two and a half years the ESM has been employed at the home. The ESM was asked why there was a buildup of dirt along baseboards, door frames and around refrigerators and the ESM replied that it was a buildup of wax and dirt layered over a long period of time

and impossible to remove without mechanical stripping the floors to remove the buildup.

The Marquise Hospitality "General Cleaning Procedures: Wall Washing" policy index ID: ES C-10-25 last revised January 21, 2015 stated wall washing was "to remove visible soil and maintain wall surfaces in order to reduce the hazards of buildup of bacteria and odour, and maintain acceptable aesthetic conditions." The policy stated this was to be done “once yearly and more frequently if required.”

The Marquise Hospitality "General Housekeeping" audit dated March 22, 2017 stated, "Floors/Carpets need to be stripped and waxed" in corridors and lounges, and "floors dirty in all dining rooms", "all floors need deep clean scrubbing" in the tub/shower rooms, and "floors dirty in all nurses stations." "General Maintenance" was also audited on March 22, 2017 and stated, "bottom edge of cupboards in all serveries need repairs/replacement, swollen due to water damage" in dining rooms, and the flooring in tub/shower rooms."

The home has identified multiple areas of disrepair and housekeeping concerns as detailed in the Marquise Hospitality audit completed March 22, 2017. The home care areas and commonly shared areas were observed for multiple areas of disrepair and unclean conditions, especially the floors and door frames throughout the building. The home had policies in place to direct housekeeping staff in the cleaning and maintenance of the home, but the dirt was layered with wax and the Environmental Service Manager and a housekeeper both shared that the dirt buildup was impossible to remove with the products and equipment in use currently.

The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary and were maintained in a safe condition and in a good state of repair.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home on April 14, 2015 as a Written Notification (WN) during the Resident Quality Inspection # 2015_216144_0019. [s. 15. (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 the home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation:
"Emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

"Physical abuse means the use of physical force by anyone other than a resident that causes physical injury or pain."

"Verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

A) The Critical Incident (CI) System report #2541-000016-17 documented an incident of

staff to resident suspected abuse. The CI documented that a resident was verbally abused during a meal service. The DOC shared that during an investigation interview with management, the Personal Support Worker (PSW) acknowledged that the incident occurred. The PSW involved in the incident acknowledged that the incident did occur where the PSW spoke inappropriately and in an unacceptable manner.

B) The Critical Incident (CI) System report #2541-000018-17 documented an incident of staff to resident suspected abuse. The CI documented that a PSW was very rough during care and caused the resident to cry out in pain. Several Personal Support Workers (PSWs) were interviewed and acknowledged that the PSW involved in the incident was rough during care that caused pain and distress to the resident.

The CI also documented an incident of suspected abuse to another resident by the same PSW on a different day. The CI documented that the same PSW was working on the unit with another resident and was providing care in a rough manner.

A PSW acknowledged during a telephone interview that the suspected PSW was abusive to two residents.The PSW shared that the suspected PSW was rough with the residents and does not work well with others.

The Responsive Health Management 2004 "Abuse and Neglect Policy" index ID: RCS P-10 last revised July 2, 2015 stated, "All residents are to be treated with dignity and respect. The abuse and neglect of a resident will not be tolerated by the Home."

The PSW involved in the incidents was terminated as the results of the investigation. The home discovered that practices and procedures had not been followed, the PSW abused residents, and the PSW breached the residents' bill of rights. The licensee failed to ensure that residents were protected from abuse and free from neglect.

The severity was determined to be a level 3 as there was actual harm/risk to this resident. The scope of this issue was widespread for three of three residents during the course of this inspection. There is a compliance history of this legislation being issued in the home as a Voluntary Plan of Correction (VPC) during a Critical Incident System inspection # 2016_263524_0032 on October 4, 2016. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #4: 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm..

The Responsive Health Management 2004 "Abuse and Neglect Policy" index ID: RCS P-10 last revised July 2, 2015 stated, "Where a staff member has reason to believe that a resident has suffered harm or is at risk of harm due to abuse or neglect, improper care or

incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the home, and to the Director appointed under the Long Term care Homes Act, 2007."

The Responsive Management INC. "Critical Incidents" policy index ID: RCS E-45 last revised March 31, 2017 documented, "Director of Nursing or designate will be responsible for communicating all critical incidents to the Ministry of Health and Long Term Care." The policy stated that regarding "Reporting Certain Matters to the Director" a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident or abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the Director."

A) A resident was observed with a sustained injury and progress notes documented an altercation between two residents where the resident sustained an injury. There was no incident report completed or a Critical Incident (CI) System Report submitted to the Ministry of Health and Long Term Care (MOHLTC) for this incident.

A progress note also documented another incident of resident to resident physical aggression where an injury was sustained. There was no documented incident report for this incident and a CI was not submitted to the MOHLTC.

The Director of Care (DOC) was asked if any CI had been submitted for the incidents and the DOC stated that the home was still deciding whether a CI should be submitted to the MOHLTC.The DOC acknowledged that there was no documented investigation and the home did not immediately report the suspicion of abuse and the information upon which it was based to the Director.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. Specifically the licensee failed to report abuse of a resident that resulted in harm.

B) The Critical Incident (CI) System report #2541-000016-17 documented an incident of staff to resident suspected abuse towards a resident. The CI was submitted three days after the incident occurred.

The DOC shared that during an interview with management, the PSW acknowledged that

the incident occurred. The ADOC was the witness to the verbal abuse of the resident and acknowledged that the suspicion of abuse was not submitted to the MOHLTC immediately.

The ADOC acknowledged that the incident involving the resident was not reported immediately to the Director. The report was submitted to the MOHLTC three days after the incident.

C) The Critical Incident (CI) System report #2541-000018-17 documented an incident of staff to resident suspected abuse. This incident was witnessed by a PSW. The CI report also documented an incident of staff to resident suspected abuse.

The DOC acknowledged that the suspicion of abuse was not submitted to the MOHLTC immediately and should have been. The DOC shared that the registered staff were to call the after hours pager. The DOC acknowledged that the home was aware of the incident nine day prior during an interview with a PSW.

The Administrator and Director of Care had reasonable grounds to suspect abuse of two residents as early as nine days prior to the date reported to the MOHLTC and did not immediately report the suspicion and the information upon which it was based to the Director until several days later.

The licensee failed to immediately report the suspicion of abuse and the information upon which it was based to the Director.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was a pattern during the course of this inspection. There is a compliance history of this legislation being issued in the home as a Voluntary Plan of Correction (VPC) for s. 24 (1) in Critical Incident #2016_263524_0032 on October 4, 2016, and a VPC in Complaint # 2016_254610_0027 on August 25, 2016. [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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #5: 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 failed to ensure that when the resident had fallen, had the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) A clinically appropriate assessment instrument: a tool used to assess/reassess a resident's specific clinical concern with the goal of determining and implementing interventions to manage the concern.

Review of the complaint information report #IL-47683-LO where the complainant voiced concerns to the MOHLTC related to a fall of a resident. Review of the Critical Incident (CI) System report #2541-000037-16 stated the resident sustained an unwitnessed fall with an injury.

The "Fall" note documentation related to the "apparent cause(s) of the fall", included

”Unknown”. The post fall assessment and actions included the notification of the Power of Attorney (POA) and a note in the physicians book. There were no “measures put in place to minimize risk of falls” as required for documentation as part of the fall note.

B) Review of the complaint information report #IL-44669-LO showed a resident sustained frequent falls with injury.

The “Fall” note documentation did not include the “apparent cause(s) of the fall”.

The Director of Care (DOC) stated that if a resident fell then a post fall assessment would be documented in the progress notes in PointClickCare (PCC) and stated that the progress note was the only assessment completed post fall.

The Responsive Health Management 2004 "Assessment of a Fall" policy last revise March 2014 stated, "Assessment of a fall must be done immediately following the fall by the registered staff. The assessment and actions taken post assessment are documented in the electronic interdisciplinary notes using the falls assessment (Risk Incident Management)."

There was no documented fall incident for the resident with respect to the sustained injury after a fall. There was no documentation of a post fall assessment.

The DOC acknowledged that the fall progress note does not have best practice to support that it was a clinically appropriate tool and shared that the registered staff were having difficulty with the changes in documentation expectations related to the actual analysis or assessment piece of the fall note.

C) Review of the Critical Incident (CI) System report # 2541-000010-17 stated the resident sustained a fall with an injury.

The Director of Care (DOC) stated a post fall assessment would be documented in the progress notes in PointClickCare (PCC) and stated that the progress note was the only assessment completed post fall.

There was no documentation related to the “apparent cause(s) of the fall”, no documentation of the “immediate actions taken (post fall assessment and actions)” and there were no “measures put in place to minimize risk of falls” as required for documentation as part of the fall note.

The DOC shared that the "Fall" progress note used as a post-fall assessment was created by corporate.

There was no documented evidence based research and literature to support the use of the corporate customized "Fall" progress note that was used as an assessment instrument for post fall assessments. The "Fall" progress note in PCC does not have the evidenced based research and literature to support its use as a clinically appropriate assessment instrument.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home as a Voluntary Plan of Correction (VPC) during Critical Incident System inspection # 2015_254610_0054 and # 2015_254610_0056 on December 15, 2015. [s. 49. (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 when the resident has fallen, had the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Observations were made of all home care areas, common areas and resident rooms. Wall surfaces had brown dried liquid splatters, floors and baseboards had a buildup of layered dust and dirt, ventilation at the ceilings had black dust spread across the ceiling, and the perimeter of flooring around dining room refrigerators had a buildup of black dirt.

Observation of resident care areas determined that in all care areas the floors have a buildup of dirt and debris along the floor perimeter with disrepair and peeled cracked baseboards. Baseboards in disrepair exposed a protruding hard edge at doorways. Hand rails were chipped, rough, and marked with black streaks. There were multiple areas of disrepair along doorways where chipped paint was observed, buildup of dirt and dust along floors in resident rooms, and bathrooms and the paint was streaked with black marks along the white painted brick walls and there was evidence of dried fluids. Most entrance door frames to the tub/shower rooms had significant dry wall disrepair at the corners.

The housekeeper shared that the build-up along the floor edge along baseboards and

doorways was almost impossible to remove because it was wax on top of dirt layered over many years. Each housekeeper was responsible for deep cleaning two resident rooms every day on each floor and each housekeeper was responsible for daily routines on two resident floors. The housekeeper shared that the floors, walls and baseboards were not easily cleaned and maintained.

The Marquise Hospitality "Floor Care and Maintenance: Stripping and Refinishing Floors" policy index ID: ES C-15-20 last revised January 21, 2015 stated the purpose was "to remove the floor sealer when it no longer responds to mopping, spray buffing and re-waxing, when the finish begins to build up along the edges or starts to turn colour. To maintain clean, attractive floors and to protect floor surfaces. To maintain a clean and pleasant looking environment, requiring minimal maintenance." The policy documented that “stripping should not be required more often than once every three (3) years and in between, floors should be wet scrubbed once every 6-18 months.”

The Marquise Hospitality "Floor Care and Maintenance: Wet Scrubbing and Refinishing Floors" policy index ID: ES C-15-30 last revised January 21, 2015 stated The Environmental Service Manager (ESM), shared the brick surface of the walls was course and almost impossible to clean, and housekeepers need to scrape the build-up. The ESM shared that some tasks do not make the priority. Discussed the dirt build up along floors, baseboards and doorways and the ESM shared it has been there for years, the build-up of dirt and wax was layered and impossible to remove without mechanical stripping of the floors.

By telephone, the ESM shared that in reviewing the maintenance and housekeeping audit dated March 22, 2017, the ESM did not have a specific understanding of the audit system responses by the auditor. The ESM verified that the audit was vague, and did not identify specific concerns related to the disrepair of baseboards in the corridors. The ESM also shared that the stripping and refinishing of the floors has not been done in the two and a half years the ESM has been employed at the home. The ESM was asked why there was a buildup of dirt along baseboards, door frames and around refrigerators and the ESM replied that it was a buildup of wax and dirt layered over a long period of time and impossible to remove with mechanical stripping of the floors to remove the buildup.

The Marquise Hospitality "General Housekeeping" audited on March 22, 2017 stated, "Floors/Carpets need to be stripped and waxed" in corridors and lounges, and "floors dirty in all dining rooms", "all floors need deep clean scrubbing" in the tub/shower rooms, and "floors dirty in all nurses stations."

The home has identified multiple areas of housekeeping concerns as detailed in the Marquise Hospitality audit completed March 22, 2017. The home care areas and commonly shared areas were observed for multiple areas of unclean conditions, especially the walls, floors, door frames and baseboards in the home throughout the building. The home had policies in place to direct housekeeping staff in the cleaning and maintenance of the home, but the dirt was layered with wax and the Environmental Service Manager and a housekeeper both shared that the dirt buildup was impossible to remove with the products and equipment in use at this time.

The licensee has failed to ensure that procedures for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces were implemented. [s. 87. (2) (b)]

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 procedures are developed and implemented for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences; that the results of the analysis undertaken were considered in the evaluation; that the changes and improvements were promptly implemented; and that a written record of everything provided for and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

There was no documented evidence that the home completed an evaluation related to the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents. There was no other documentation provided by the home as to what changes and improvements were required, that the changes and improvements were promptly implemented and that a written record of everything.

The DOC and the Quality Improvement Educator (QIE) stated that they were unable to locate an evaluation related to the policy to promote zero tolerance of abuse and neglect of residents. Both stated they were unaware that an evaluation was required as outlined in the regulation.

The Director of Care stated that they were unable to locate an annual evaluation of their abuse policy.

The Responsive Health Management 2004 "Abuse and Neglect Policy" index ID: RCS P-10 last revised July 2, 2015 stated, "This policy is to be reviewed on at least an annual basis to evaluate its effectiveness, including whether and changes are necessary. Any changes to this policy are to be promptly implemented. A written record of the review is to be maintained, including a summary of the items analyzed, the names of the persons participating in the review and any changes that were made, including the date(s) of implementation."

The licensee failed to ensure that at least once in every calendar year an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread during the course of this inspection. There is a no compliance history of this legislation being issued in the home in the past three years. [s. 99.]

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 at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences; that the results of the analysis undertaken are considered in the evaluation; that the changes and improvements are promptly implemented; and that a written record of everything provided for and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared, to be implemented voluntarily.

Issued on this 26th day of September, 2017

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

Original report signed by the inspector.