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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Nov 2, 2015	2015_265526_0021	H-003341-15	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA FORUM
175 FORUM DRIVE MISSISSAUGA ON L4Z 4E5

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

VILLA FORUM
175 FORUM DRIVE MISSISSAUGA ON L4Z 4E5

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

THERESA MCMILLAN (526), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), MELODY GRAY (123)

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): October 2, 6, 7, 8, 9, 13, 19, 20, 21, 22, and 23, 2015.

The following Complaint Inspections were conducted simultaneously to this RQI Inspection: H-001976-15 (Bedtime and Rest, Duty to Protect, Responsive Behaviours);
H-002239-15 (Bill of Rights, Recreation and Social, Menu Planning);
H-002250-15 (Menu Planning, Dining and Snack Service, Falls Prevention and Management, Plan of Care, Bathing, Duty to Protect, Housekeeping, Recreational and Social, Elevators);
H-002500-15 (Bathing);
H-002931-15 (Housekeeping, Menu Planning);
H-003049-15 (Cooling Requirements, Housekeeping, Dining and Snack Service, Food Production);
H-003149-15 (Food Production).

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Services Supervisor (ESS), Food Services Manager (FSM), Co-Directors of Care (Co-DOCs), Assistant Director of Care (ADOC), Program and Service Manager, Registered Dietitian, (RD), Administrative Assistant, Nursing Unit Clerk, Business Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Personal Care Providers (PCPs), Dietary Aids, Housekeeping staff, residents, and family members.

During the course of this inspection, inspectors toured the building (resident rooms, common spaces including dining rooms, tub/shower areas, the kitchen and serveries); reviewed health records, policies and procedures, menus, food production recipes, recreation schedules and participation flow sheets, maintenance logs, houskeeping audits, elevator service reports, emergency plans, and air temperature logs; measured illumination levels; observed care, residents, and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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

- **11 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #042's Resident Assessment Inventory Minimum Data Set (RAI MDS) completed in 2015, indicated that the resident had an uncorrected sensory deficit. The associated Resident Assessment Protocols (RAPS) described modifications to accommodate this deficit. During interview, a Personal Support Worker (PSW) stated that the resident had not had correction since admission and described modifications as mentioned in the RAPS. Review of the resident's plan of care revealed no entry for the resident's sensory deficit. The Co-DOC confirmed this. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) Resident #021 required treatment three times per week for a health condition. On a specified day in 2015, they had a procedure and external clinic staff provided ongoing daily care instructions to the Long Term Care Home staff. Review of resident #021’s plan of care indicated that these daily care instructions were not included as outlined by the clinic staff for LTC staff to implement.

During interview, almost three weeks following the procedure, the resident told the Long Term Care Homes (LTC) Inspector that they were concerned and worried that staff hadn't been following the daily care instructions provided by the clinic staff during at least 4 days in this time frame.

During interview the Nurse Manager confirmed that staff were supposed to monitor the resident daily and document the observation. The Nurse Manager could not confirm if all staff had performed this as there were only two notes to indicate that this had been completed. The Nurse Manager confirmed that resident #021’s plan of care did not direct staff to monitor the resident daily.

During interview, the Co-DOC confirmed that resident #021’s plan of care did not give clear direction to staff who provided care in relation to daily monitoring and ongoing care. (526)

B) Review of health records indicated that resident #025 had a health condition that required the administration of a specialized medication over an 11 month period between 2014 and 2015; this was confirmed by direct care staff. During this time, the resident was hospitalized twice with a related condition. Review of the resident's plan of care indicated that it did not include directions to staff about the care requirements related to the specialized medication for almost six months during this time period.

During interview, the Co-DOC confirmed that the care required by resident #025 regarding the administration of the specialized medication was not consistently part of their plan of care. The DOC confirmed that resident #025’s plan of care did not give clear direction to staff related to care requirements regarding the administration of the specialized medication. (526)

C) Resident #043 had multiple areas of altered skin integrity located on an extremity.

In an interview with the resident's Substitute Decision Maker (SDM), the family member indicated they would often notice a very strong odour coming from the resident's extremity. Review of progress notes during October 2014, included that the SDM complained to staff about the odour and soiled clothing that covered the extremity; staff responded that interventions were in place to address these concerns.

Review of the resident's health record confirmed that these interventions were not put into the documented care plan, which front line staff used to direct care, thus clear direction was not provided to the staff to ensure the resident's care was provided as planned. (586) [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care for resident #011 was based on an assessment of the resident and the needs and preferences of that resident.

Resident #011 had a shower scheduled on two days of each week, and as needed (PRN).

i) During an interview with the resident's family member, they voiced concern regarding the resident's appearance and personal hygiene. The family member indicated that they recently requested that the resident receive hygiene interventions more frequently and according to their needs, though had not received any follow-up regarding this matter.
ii) Observation of the resident on four days during this inspection, revealed poor personal hygiene that was confirmed by the registered staff.
iii) Review of the resident's flow sheets for a ten month time frame in 2015, revealed they had received hygiene interventions according to their needs for the first seven months. However, these were not provided beyond the basic hygiene care over the next three month time period.
iv) Interview with the Co-DOC's confirmed the resident had a need for additional personal hygiene interventions and was not currently receiving the care to meet these needs. A Co-DOC also confirmed that resident #011's needs should have been added to their plan of care. [s. 6. (2)]

4. The licensee failed to ensure that resident #043's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #043's Minimum Data Set (MDS) Assessment completed in 2014, indicated the resident's use of one bed rail daily, and the next assessment completed four months later indicated bed rails were no longer used.
i) An interview with resident #043's SDM revealed that they had not been consulted prior to the removal of the resident's bed rails.
ii) Review of the resident's health record did not include any documentation regarding when the rails were removed or any consultation with the resident's SDM for approval.
iii) Interview with a Co-DOC confirmed that they could not provide evidence that the SDM had been given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #042's admission Resident Assessment Protocol (RAP) completed in 2014, indicated that the resident was usually continent and also had an intervention discontinued. However, the two documents the home referred to as the care plan completed i) 10 days and ii) three months later continued to include care as though the intervention was still in place and that the resident was continent; no plan regarding management of continence was indicated.

Progress notes completed approximately 10 days following the RAPS, reported that the resident had an alteration to skin integrity that was worsened by incontinence. During interview, a Co-DOC confirmed that the care plan had not been updated when resident #042's care needs changed after the discontinuation of an intervention.

B) Review of resident #042's health record revealed that their bowel continence deteriorated over a three month time period in 2015. Interviews with PSW staff and review of the written plan of care did not indicate that the resident's bowel continence had deteriorated. A Co-DOC confirmed that resident #042's written plan of care had not been updated when their care needs had changed.

C)Resident #043 was at a high risk for falls.

i) The resident experienced a fall out of bed on a specified day in 2014. The Post-Fall Assessment completed by the Nurse Manager indicated that the resident would be assessed for a falls prevention strategy.

ii) The resident experienced another fall out of bed two weeks later; the falls prevention strategy was not in place at the time, and was not implemented as an intervention until the day after the second fall.
iii) Review of the resident's health record indicated that it did not include an assessment of the resident for the use of the falls prevention strategy. During interviews, the Nurse Manager and a Co-DOC could not provide an explanation as to why the resident did not receive the intervention after the initial recommendation following the first fall. [s. 6. (10) (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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident and (c) clear directions to staff and others who provide direct care to the resident; and that that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were implemented for cleaning of the home, specifically flooring in resident rooms, resident bathrooms, lounges and serveries.

A) Resident room flooring material was observed to be made of square tiles and resident bathroom flooring made of textured non-slip sheet vinyl. Wear patterns, discolourations (black) and dark areas were observed in but not limited to rooms #427 (bed), 421(both), 420 (bath), 415 (bath), 345 (bath) 330(bath), Napoli and Venezia lounges (scuffed, pitted, scratched), 352A(bath), 245 (bath), 214 (both), 218 (bath), 221 (bath), 226(bath), 227(bed), 233 (bath), 236 (bath) and Roma dining room.

B) The non-slip vinyl sheet flooring was black in appearance throughout each servery in every home area. According to the Administrator, the floors were scheduled to be replaced with tile in November 2015.

According to the home's various procedures regarding floor care dated January 2015, floors were to be either buffed, polished, top scrubbed or stripped and re-waxed based on appearance and need. No established frequencies were identified for resident room floor buffing or top scrubbing, but a statement in the policy identified that the "top coat would be removed from the floor when the floor is starting to accumulate soil but is not heavily soiled to warrant stripping and refinishing". The policy titled "Buffing" identified that "heal marks and scuff marks" would be removed, but did not identify where exactly the process needed to be completed (such as resident rooms). It is implied that some form of auditing would need to be conducted to establish which areas would need to be buffed, top scrubbed or stripped and re-waxed and a schedule developed. According to the (Environmental Services Manager) ESM, 29 rooms that were vacated between January and October 2015 had the floors stripped and re-waxed. However, he did not have any audits, lists or schedules available as to when other resident rooms were audited, completed or if they were due for some form of floor care.

The home's floor care procedures identified that lounges and dining rooms would be spray buffed weekly (to remove scuffs, dirt and marks) and serveries were to be scrubbed with a machine weekly (to remove build-up of dirt). Based on the degree of floor discolourations, marks, scuffs and general appearance, the floors were not being maintained in accordance with established procedures and policies. [s. 87. (2) (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 procedures are developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance under clause 15(1)(c) of the Act, the licensee did not ensure that schedules or procedures were in place for remedial and preventive maintenance.

Maintenance services in the home were being managed by a contracted service provider. According to the Environmental Services Manager (ESM) and the contracted service provider’s maintenance policies, no specific written procedures were in place to guide maintenance or designated staff in their role in conducting preventive maintenance duties related to the condition of floors, fans, lights, walls and furnishings/cabinetry. In all cases below, a series of forms had been created to keep track of work completed and verbal expectations set by the contracted service provider however the forms were not completed and verification could not be made as to the extent of the work completed or what work was pending.

A) During the inspection, the flooring conditions were observed and discussed with the

ESM, some of which he was aware of and others that he was not. No policy or procedure was available in the home's maintenance manual to direct staff to monitor the condition of flooring in all areas of the home or a schedule of repair or audit identifying their condition.

i) The flooring material in 17 bathrooms had a seam running the length of the room that was split. The flooring material in bathroom #123A and #425 was ripped (not at the seam).

ii) The flooring material was observed to be loose and lifting in the corridor to room #423, Palermo lounge or kitchenette (4 tiles lifting by the sink/cabinets) and room #223 (just inside the bedroom). Tiles were lumpy and uneven just outside room #323 and 10 tiles were lifting and badly chipped in front of the balcony entrance in the Roma Lounge or kitchenette.

B) During the inspection, numerous exhaust fans located in resident rooms and tub rooms were turned on and noted to be overly noisy or not functioning. The condition of the fans was discussed with the ESM who reported that he was aware of the issue and was replacing 3 motors per month, as the budget allowed. The contracted maintenance consultant provided a document titled "Quality Action Plan" dated January 9, 2015 that described actions to be taken to address the "defective and noisy fans" which were confirmed by the consultant during an audit in October 2014. The options included replacing the fans, repairing them, ensuring they are cleaned regularly and any condition issues reported and spot auditing 12 fans per month. An exhaust fan condition audit (not dated) was last completed according to the ESS in March 2015 and identified numerous noisy or non-functioning fans. No follow-up action was identified on that particular audit. Documentation identified as the "Maintenance Audit Form" provided by the consultant identified that only 9 fans were replaced between January 1, 2015 and October 20, 2015. The home's maintenance policy for exhaust fans (06.08) identified that exhaust fans were to be maintained for optimal performance on a monthly basis. However the policy did not identify whether this included exhaust fans in resident bathrooms or other exhaust fans within the building (i.e. kitchen, laundry). A reference was made that a certified technician was to inspect the fans on a quarterly basis, and that the bearings would require lubrication every 2 months, which would be very time consuming and not necessary for standard domestic fans. Neither of these actions was completed by anyone in the home. Based on the "Quality Action Plan" (which described replacing 4 fans per month) it would take 9 months to replace all of the fans identified below and would not take into account any other fans failing over the course of those 9 months.

During tour of the home, it was noted that at least 34 resident bathroom fans and those in Napoli and Palermo tub rooms were noisy or not working.

C) During the inspection, many light bulbs over resident bathroom vanities, top bulb on the over bed lights and lights in shower areas were found to be burnt out. The home's maintenance manual did not include interior lighting requirement procedures or policies. A maintenance document was provided which revealed that 22 light ballasts and several light switches were replaced between January 1 and October 20, 2015, as a remedial step, but no preventive or specific audit was completed (identifying what areas were visited and when). Maintenance logs (kept at each nurses' station) were reviewed and several notations of burnt out lights were noted in the logs, but staff did not identify the lights that were observed to be burnt out during the inspection. The process was very much remedial in nature and did not include a preventive component, where a designated person would conduct an audit to determine the location and number of light bulbs requiring replacement and a schedule developed to address the deficiencies.

The following light bulbs were burnt out in but not limited to the following areas: Rooms #109 (over bed and main light in bath), 111 (over bed), 114A (over bed), 116, 130, 272 (vanity and over bed), 275B (over bed), 214, 215, 221, 223, 237, 371, 372(over bed), 368, 352A, 347, 337, 325, 320, 318 (vanity and over bed), 319, 317 (over bed), 314 (over bed), 312, 452, 434, 427, 420, 415, 412, Palermo, Napoli, Venezia, Firenze, Milano and Roma shower rooms and Consenza and Palermo tub rooms.

D) During the inspection, the walls were observed to be in a state of semi-repair in many areas. The walls were patched at some point, but no schedule, list or audit was available to determine when they were patched and when they would be sanded and painted to complete the process. According to the ESS, they were in the process of hiring a person to complete painting and patching throughout the home. The maintenance manual was reviewed with respect to wall repair, painting requirements and expectations, but no wall maintenance policy or procedure was available in the maintenance manual. The ESM was able to produce several documents that revealed the dates and rooms where he had re-painted 29 vacated resident rooms and several dining rooms since January 1, 2015. Only one document for the Milano home area was provided that included a schedule of action taken and actions pending. The ESM described that his process of auditing areas in need of patching and painting was informal, based on what he saw while touring the home on a daily basis and documenting the required work in his calendar. According to the contracted service consultant, several tracking and auditing forms had been

developed for use by the ESM, but the expectation was not identified in a written maintenance procedure. The following issues were observed at the time of inspection and is not a full list of what was observed:

i) Wall damage was evident in rooms #452 (bedroom), #412 (bedroom - frequent repairs made to the same locations), #371 (gouged bath), #227 (bath - scuffing heavy with gouges), #225 (bath – hole under heater, lots of patching), #223 (bath - scuffing heavy), #237 (many divots in the bed wall), #216 (bath - scuffing and peeling, #123A (bath -paint peeling badly), 3111 (bath), #112(bedroom -gouged and scuffed). Discussed alternative wall protection options with ESS for resident rooms where damage is frequent or re-occurring.

ii) The material used to enclose the pipe next to hand sinks in the Firenze, Roma and Venezia dining rooms was damaged (exposed particle board) and could not be cleaned.

iii) Wall patching was noted throughout the home and extensive in the Palermo Shower room, Venezia tub room, Roma tub room, Roma dining room, Napoli dining room, in resident rooms 375, 118, 236, 237 (bath). A family member reported that the patch job in one identified resident's bathroom was patched several months prior and not completed (sanded and painted).

E) During the inspection, the lower cabinet doors in the Firenze, Consenza, Napoli and Milano kitchenettes were damaged around the edges (exposed particle board) and could not be cleaned in that state. A style of wooden chair throughout the home was observed to have arms and legs that had lost it's coating of stain and varnish, revealing raw wood and a surface that may be more difficult to keep clean. Both observations were previously identified by an Inspector during an inspection completed on October 27-November 7, 2014. No action had been taken regarding the cabinet doors until after the issue was identified to the consultant of the home's management company on October 8, 2015. Many of the chairs were in the process of being replaced at the time of inspection and the Administrator reported that more would be replaced in 2016. A process to ensure that current chairs and the new chairs in the home remain in good condition was not evident. A review of the maintenance manual confirmed that no policy or procedure was included that would guide maintenance staff in maintaining cabinetry or furnishings and what the expectations would be. No schedules or audits were in place for 2015 to identify which chairs or cabinetry required attention or would require attention in the near future.
[s. 90. (1) (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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #4: 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 were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #043 was at a high risk for falls.
i) The resident's Minimum Data Set (MDS) Assessment completed in 2014, indicated the resident's use of one bed rail daily, and three months later the assessment indicated bed rails were no longer used.
ii) Review of the resident's health record did not include any documentation as to when the rails were removed, and did not include the reasoning why they were removed until after the removal.
iii) Interview with the Nurse Manager and a Co-DOC confirmed the resident's safety in bed without the rails was not assessed. [s. 15. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained in the home's shower rooms.

The home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "In all other areas of the home". A hand held analogue light meter was used (Sekonic Handi Lumi) to measure the lux levels in all of the shower rooms in each home area. The meter was held a standard 30-36 inches above the floor and held parallel to the floor. No windows were available in any shower room and lights were turned on 5 minutes prior to measuring. Each shower room was equipped with pot lights with an opaque lens. The pot lights were located in the shower and/or in the entrance way. Some shower rooms were equipped with a mixture of fluorescent tube lighting and pot lights. The lux levels under the fluorescent tube lights were satisfactory. Many of the pot lights were found to be burnt out, but where they were fully operational, a measurement was taken directly under the lit pot light. A lux of 50-100 was achieved, which is well below the required level of 215.28 lux. [s. 18.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident’s care was held within six weeks following the resident’s admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Resident #011’s last care planning conference occurred on a specified day in 2014, as documented in the resident’s health records. Review of the health record and interview with a Co-DOC confirmed there was no record of another care conference occurring since then, a time period greater than one year. [s. 27. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

Review of health records revealed four physician orders related to the administration of a specialized medication to resident #025 over a seven week time frame.

Review of the home’s electronic medication administration record (eMAR) documentation system revealed that the medication administration as per physician orders, to resident #025, had not been transcribed onto the eMAR or documented between the initial order and seven weeks later. During interview, the Co-DOC confirmed this, stating that the resident had received the medication and that it was the home’s expectation that medication orders be transcribed to the eMAR and documented. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by a method of their choice.

Review of resident #045's health records and staff interviews indicated that the resident was a reliable historian and that they required assistance with bathing and transfers.

Review of health records and PSW interview revealed that on two specified days (one week apart) during 2014, documentation indicated that the resident had not received their scheduled bath/shower. During interview, the unit clerk responsible for staffing confirmed that resident #045's home area was short staffed by one PSW on the first day where a bath/shower was missed.

On the day of the second missed bath/shower, resident #045 notified the Ministry of Health and Long Term Care (MOHLTC) that they had not been bathed because the home was short staffed. During interview the resident confirmed this, saying that they were not bathed during two consecutive weeks, that they were not offered a replacement for these, and that the home was short staffed. [s. 33. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Upon admission in 2014, resident #042's Resident Assessment Inventory Minimum Data Set (RAI MDS) indicated that the resident's was mostly continent of bowel and bladder. During interview, a Registered Nurse stated that residents' continence was assessed on admission to the home and at any other time when continence deteriorated.

A) Bladder continence: Review of health records indicated that the resident's bladder continence deteriorated between their admission and four months later and that an assessment of their bladder continence had not been completed when there was a deterioration. During interview, registered staff and the Co-DOC confirmed that resident #042's bladder continence had not been assessed using an instrument specifically designed for continence when bladder continence deteriorated between admission and four months later.

B) Bowel continence: Review of resident #042's health record indicated that there was a deterioration in their bowel continence over a three month period in 2015 and no continence assessment was found in the health record.

Review of the non registered staff documentation indicated that the resident was incontinent of bowel on 10 occasions during the third month of this time period. However, the plan of care indicated that the resident was usually continent of bowel. In addition, they were at risk for alteration in skin integrity in and around the brief area.

During interview, an RN and the Co-DOC confirmed that resident #042's bowel continence had not been assessed using an instrument specifically designed for continence when bowel continence deteriorated. [s. 51. (2) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Resident #046 was initially admitted to the home in 2014. According to their health record, between admission and approximately four months later, the resident exhibited responsive behaviours that were known to be disruptive to a co-resident, especially at night. Progress notes included at least 27 documented entries about these behaviours during these four months.

Review of the home’s complaint log revealed a written complaint to the home by resident #040 regarding resident #046’s behaviours and how these behaviours negatively affected the complainant during the four months since resident #046's admission.

Review of resident #046’s plan of care for four months after their admission, indicated that there were no written strategies to manage their night time behaviours. During interview, the home area RN confirmed that resident #046’s behaviours disturbed resident #040’s sleep and described interventions staff had used to manage these behaviours. The RN confirmed that resident #046’s written plan of care for approximately four months after admission, did not include these strategies to meet resident #046's rest and sleep needs that also led to sleep disruptions of co-resident #040. [s. 53. (4) (b)]

WN #11: 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. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's drug destruction and disposal policy included that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

On October 21, 2015, the Long Term Care Homes (LTC) Inspector observed controlled substances that were discontinued greater than 20 days previously and to be destroyed, that were located in the locked compartment in the medication cart together with controlled substances that were being administered to residents. During interview, a Registered Practical Nurse (RPN) stated that staff were to bring the medications to the Co-DOC for storage until destruction and disposal. However they stated the home’s system for destruction of controlled substances was not very timely and discarded controlled medications could sit in the medication cart with other controlled medications for quite some time.

The home’s “Narcotics” policy LTC-CA-WQ-200-06-14 last reviewed July 2015 stated: "All narcotics/controlled drugs are counted until the discontinued drugs are removed by Director of Care or designate to a locked Narotic surplus drawer/cabinet in a locked room. Prior to placing the discontinued narcotics in the locked area, the DOC and Registered Staff will completed the Log Record of Narcotics for Destruction".

During interview, the DOC confirmed that
i) the policy did not include that, controlled substances that were to be destroyed and disposed of should be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred; and
ii) the home’s policy did not provide specific direction to staff about the timeliness for the removal of discontinued controlled medications away from those currently being administered. [s. 136. (2) 2.]

Issued on this 22nd day of November, 2015

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

Original report signed by the inspector.