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
Oct 20, 2017	2017_552531_0028	022096-17	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WEST LAKE TERRACE
1673 COUNTY ROAD, 12 R. R. #1 PICTON ON K0K 2T0

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

SUSAN DONNAN (531), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 6, 10, 11, 12, 16 and 17, 2017.

The following intake logs were inspected concurrently during the inspection:
Log #003358-17 alleged abuse
Log #029144-16 follow up inspection related to infection prevention and control

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care; Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Nutritional Care Manager (NCM), the Clinical Care Coordinator (CCC), the RIA Coordinator, the Life Enrichment Coordinator (LEC), a Cook, the President of the Residents' Council, the President of the Family Council, residents and residents' Substitute Decision Makers (SDM).
During the course of the inspection the inspectors conducted a tour of the home, reviewed resident health care records, observed resident care and services, reviewed medication administration and practices, observed dining services, reviewed resident council minutes, reviewed the family council meeting minutes, observed and reviewed infection control and prevention practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (3)	CO #001	2016_280541_0026	531

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident # 031 as specified in the plan with respect to fall prevention.

Resident #031 had been assessed as being a high risk for falls.

On a specified date, the resident was found on the floor, the resident had not sustained an injury as a result of the fall.

The resident's plan of care in effect at the time of the fall specified various falls prevention measures.
Following the fall, RN #111 noted that not all of resident #031's fall prevention measures were in place at the time of the fall.

On October 17, 2017 during an interview with RN #111 and review of the post fall documentation, she indicated that she had checked on resident #031, a few minutes prior to the incident and the resident was asleep. RN #111 indicated resident #031 was assessed and had not sustained an injury as a result of the fall. She indicated that following the assessment of the resident she noted that not all fall preventive measures were in place at the time of the fall.

The Administrator/DOC was interviewed and indicated it is an expectation that all staff ensure all fall prevention measures are in place and working as outlined in the resident plan of care. She indicated all PSWs involved were provided education following the incident. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, 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 are maintained in a safe condition and in a good state of repair.

During the course of the inspection the inspectors noted the following areas of disrepair:

Room 101
Some scuffs noted on door frame and on wall around bathroom door
- wood gouged out of bathroom door, finish worn off of foot board of bed

Room 102
-wall and door frame around bathroom scuffed, outer piece of door handle on bathroom loose and coming off

Room 103
- scuffs on wall and door frame around bathroom

Room 104
-scuffs and scrapes on bathroom door and around door frame
-the bathroom door the wood was gouged, splintered and heavily scarred

Room 106
-scuffs/scraps on and around doors - finish wearing off door knob to bathroom

Room 107
-door knob to bathroom loose, sharp edges

Room 108
-Scuffs and scrapes on and around door frames of door into bedroom and bathroom

Room 111
- bathroom sink out let drain was corroded with rust around sink drain,
-chips and gouges of wood out of main door to room approx. 60 cm of lower door frame
-the lower 60 cm of the entrance door to the room and the washroom, heavily scarred, wood splintered, paint worn/damaged exposing wood base
-large area approx. 300cm x 400cm left wall beside the clothes closet, has not been painted

Room 114
-sink had a crack approx 16 cm in length from sink drain to the outer edge of the sink.
- the lower 20 cm of the bathroom door frames are heavily scarred, paint off, exposing steel frame

Room 115
-the right wall across from bed A, the lower 12 cm scarred, drywall gouged, paint chipped
-bottom edge of the clothes closet doors, splintered
- outside edge of the left closet door, splintered approx. 6 cm along outer edge next to bedside table

Room 116
- clothes closet splinter across the bottom of both closet doors
- center of outer edge of the left door next to the resident bedside table splintered with sharp edges
- handle to the bathroom door was loose and base detached from the door.
- bottom interior base of the toilet stained, pink/black/dark gray, encompassing the lower surface from the water level in the bowl East hall

Room 117
-approx 90 cm of both sides of the lower portion of the entrance door frame were heavily scarred, black marks, paint chipped off exposing splintered wood base
 -lower 30 cm of the right entrance wall, the drywall was chipped and scarred
- floor trim along the left wall broken, pieces missing sharp edges
-approx. 45 cm of floor trim detached from the wall, area approx. 30 cm above the floor trim there were multiple gouged areas of drywall paint chipped.
-bathroom sink outlet drain was corroded surrounding outer edge of the drain

Room 118
- rust surrounding sink outlet drain towel rack observed with visible rust

Room 119
-rust surrounding outer edge of the sink outlet drain

Room 121
-washroom sink drain corroded/rust around the outside edge of the outlet drain
-approx. 60 cm of the lower entrance door frame the wood was gouged, splintered, sharp edge

Common areas:

Tub/Shower area:
- entrance door to the tub room, inspector the lower 90 cm of the wooden door frame was heavily scarred, exposing wood base, the base was splintered, gouged and paint missing
-the kick plate was also broken along the edges with two edges detached from the door

East hall
- the lower approx. 60- 75 cm of the wooden door frames of the resident entrance doors for room 105-111, the door frames were noted to be heavily scarred, wood splintered, exposing the wooden door frames, the areas were also noted with multiple black marks

- a electric baseboard heater located in the east hall near the tub room that was noted to be heavily scarred, with black marks the length of the heater cover. The heat cover was noted to be ill fitting.
-floor trim to the right of the entrance door to room 110, there was a piece approx. 30 cm in length of trim missing, exposing two steel sharp base clamps/holders, where the trim was once attached.
- the floor trim in the hall between room 111 to the fire doors, approx. 90 cm of the lower right wall, had multiple drywall chips approx. .5 to 1 cm, paint chipped, with heavy black marks the length of the area.
-fire doors lower 45 cm there is approx. 60-75 cm area were the paint is missing exposing the steel door
- the hall by room 104 there was approx. 90 cm were the concrete was damaged, rough, sharp edges, corner trim missing.

-black/dark brown concrete filled patch above the door frame of the access door leading to the downstairs, across from room 104.

- Small dining area to the north of the main dining room, the lower approx. 10 cm X approx. 60 cm the burgundy paint noted with multiple drywall chips, paint missing.

-the wing back chair in the small lounge across from the nurses station the legs of the wing back chairs, the wooden legs are heavily scarred, splintered, wood stain worn off.
- the lower approx. 90 cm of the entrance door to this area the wooden door frame was noted to be splintered, heavily scarred and paint missing.

-the small tv lounge across from the Administrators office, a wing back burgundy chair with a tear in the cloth seating cushion approx. 7cm in length
-the wooden legs are worn, wood splintered, stain worn off.

During an interview and walking tour of the areas of disrepair with the Administrator, she acknowledged the areas of disrepair, indicated that the areas would be prioritized and addressed. [s. 15. (2) (c)]

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 the home, furnishings and equipment 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 3(1)(11)(iv) whereby the resident has not had his or her personal health information kept confidential.

On October 11, 2017 RN #100 administered morning medication to residents # 021 and #040 and left their personal health information pertaining to medication open and visible on the Electronic Medication Administration Record (EMAR) screen, located in the hall. During the time that the personal health information was visible on the medication management screen resident #001 and #026 were passing the cart on their way to the dining room, the maintenance staff and housekeeper were also in the vicinity of the cart.

Inspector #531 observed RN #100 in the dining room administering morning medications to a resident and the medication management screen was open and visible with photos and health information for resident #003, 006, 011 and 043. During this time resident #10 and #044 were passing the cart going to the dining room. The maintenance worker and laundry aide were also in the vicinity of the cart at this time.

During the morning medication pass on October 11, 2017 RN #100 was observed placing residents individual medication packages in the regular garbage on the side of the cart. RN #100 indicated that she tears the resident surname from the package and disposes the package in the regular garbage. RN #100 indicated that at one time the practice was to soak the individual medication packages in water, removing all personal information, however she was not aware of the current practice.

Inspector #531 observed medication administration strips for resident #026 and 040 in the garbage, and only the last two letters were removed from the strip.

On October 11, 2017 during an interview with RPN #101 she indicated that she soaks the individual medication packages in water to remove all personal health information then disposes the packages in the garbage.

The Administrator was interviewed and indicated that the individual resident medication packages are to be soaked removing all personal health information or shredded and disposed of in regular garbage, and that the electronic medication administration record should be minimized or close to protect resident personal health information. She indicated that the resident personal health information was not kept confidential. [s. 3. (1) 11. iv.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1) 1.2 in that a door that leads to a non-residential area was not kept closed and locked when not supervised by staff.

On October 4, 2017, a family member of a resident in the home indicated to inspectors that on many occasions the staff bathroom door has been left open, when it should be closed and locked to restrict resident access.

On October 5, 2017, at 0905 hours, the door to the staff bathroom was observed to be left open with no staff in the area. The door was closed and locked by the inspector at the time.

On October 6, 2017, at three different times throughout the day (0850 h, 1230 h and 1415 h) it was observed by the inspector that the door to the staff bathroom was left open and no staff were in the area.

On October 6, 2017 the Administrator was interviewed and indicated that the staff bathroom door was to be locked at all times when not in use. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 73(2)(b) in that residents who require assistance with eating or drinking were served part of their meal before someone was available to provide the assistance required.

During the lunch meal on October 10, 2017, the following was observed by Inspector #197:

- Resident #030 was observed at 1204 hours with soup sitting on the table in front of the resident and no staff present. At 1209 hours, staff sat down and began to feed the resident the soup.

- Resident #041 was observed at 1204 hours with soup sitting on the table in front of the resident and no staff present. At 1214 hours, staff sat down and began to feed the resident the soup.

Staff did not reheat the soup for either resident.

The current care plan for both residents indicates they require total feeding assistance by staff.

On October 16, 2017 during an interview the Nutritional Care Manager indicated that there had been an increase in the number of residents that required assistance. [s. 73. (2) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substance for resident #009, #015 and #042 were locked in separate locked area within the locked medication cart.

On October 11, 2017 inspector #531 observed the storage of medication in the medication cart utilized by RN #100 during the morning medication pass. Inspector #531 observed controlled substances for resident #009, 015 and 042 that were not locked in a separate area of the locked medication cart:

During an interview with RN #100 she indicated that the registered nurses assist with only the morning medication pass for approximately fourteen residents to ensure medications are administered in a timely manner. RN #100 indicated that there is only one medication administration cart, and to save time she transfers the medication for the residents to the treatment administration cart (TAC) including controlled substance medication. She indicated that the cart does not have a separate locked area for controlled substance therefore the controlled substance medications are not double locked for the duration of the medication pass.

The Administrator was interviewed and indicated that controlled substance are to be locked in a separate locked box in the bottom of the locked medication administration cart to ensure the controlled substance are double locked. [s. 129. (1) (b)]

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Issued on this 20th day of October, 2017

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

Original report signed by the inspector.