Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2014	2014_303563_0018	L-000671-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE WESTMOUNT
200 David Bergey Drive, KITCHENER, ON, N2E-3Y4

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

MELANIE NORTHEY (563), JULIE LAMPMAN (522), JUNE OSBORN (105), RHONDA KUKOLY (213)

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): June 24 - 27 and 30, 2014

Concurrent inspections: L-000636-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Clinical Services (DCS), the RAI Coordinator (RAI-C), the Social Worker, the Food Services Manager (FSM), the PCP Coordinator, the Environmental Service Manager (ESM), forty-one Residents, three family members, one Restorative Aide, one maintenance staff member, three Registered Nurses (RN), eight Registered Practical Nurses (RPN), two housekeeping staff, and thirteen Primary Care Providers (PCP).

During the course of the inspection, the inspector(s) conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

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
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 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 failed to ensure that the home, furnishings and equipment are

maintained in a safe condition and in a good state of repair in the following Resident Home Areas (RHA):

1 a) Kingsdale RHA observations on June 24, 2014 by inspector # 213:
- 2 doors to the lounge area have chipped and peeling paint on the door frames
- the end of the hand rail was missing on the wall beside the MUD room and across from the nursing station, leaving a sharp unfinished edge

RPN confirmed that these areas are in disrepair and should be repaired for resident and family quality.

1 b) Kingsdale RHA observations on June 24, 2014 by inspector # 522:
- MUD Room and SPA room 160 had paint scraped on the door and door frame
- the end of the hand rail was missing between the MUD room and the SPA room on either side and where the corner handrails were attached to the wall the paint has not been repainted in that area
- linen cupboard door paint was chipped on the door and door frame
- sitting area at end of hall observed to have two holes in the wall

1 c) Kingsdale RHA observations on June 25, 2014 by inspector # 563:
- SPA room 160 shower head dripping water continuously. Housekeeper confirmed shower head has been dripping for several months and repairs have been logged in the "Maintenance Request" binder, but never repaired.

2) Forest Hill RHA observations on June 24, 2014 by inspector # 522:
- numerous door frames with chipped paint
- MUD Room door had a gouge across the door and part of hand rail was missing near the door and paint on wall was not repaired
- door beside MUD room had paint chips

3 a) Pioneer RHA observations on June 24, 2014 by inspector # 105:
- carpet was stained on entry to RHA with stains on the carpet sporadically around the unit
- linen cupboard door by room 214 was scratched through the paint
- end of the hand rail is missing on the wall beside the MUD room and across from room 209

3 b) Resident room observations in Pioneer RHA on June 24, 2014 by inspector #

105:
- Room observation for 4 residents revealed a small hole in the wall behind the door, there was paint scratched off the door frame and it was worse on the right side, the wall at the entrance of one room and to the right had 3 gouges out of the wall and other scrapes close to the base board and the caulking was lifting around the washroom sink

3 c) Pioneer common area observations on June 24, 2014 by inspector # 105:
- SPA Room 255 wall was damaged under the sharps container to the left just inside the door. The red flooring was lifted with an 8 inch gap where it joins to the brown flooring in the shower area. There was a small collection of dark debris between the tiles at the entrance to the shower area.
- Jacuzzi Room 266 cabinet below the sink was damaged showing the pressed wood below and covering approximately 2x3 inches, the wall was damaged near the toilet, entrance to this area revealed chips through the plaster at the corners with black scuff marks on wall beside the toilet and just inside the door entry.
- Living Room 256 has large patched area of plaster starting at the top of the window and around the top corner to the inside of the window and down the wall 4.5 feet and this area was not painted. Paint was scraped inside the door to the right, and on the door frame on entry.
- Family Room 267 has flooring missing under the sink. The radiator under the window was moderately scratched through the paint, also the bottom of the fridge and the wash machine were scratched.
- Dining Room 268 large and small window frames were scratched, the radiator was scratched and multiple black marks noted along its entirety, and windows open 5 inches to the roof top which had weeds that were visible in the dining room. There was noted wall damage through the plaster by the first table to the right upon entry and the chair rail close to the sink had some paint scratches in two areas measuring 6 inches and 8 inches.

4 a) Williamsburg RHA observations on June 24, 2014 by inspector # 522:
- numerous paint chips on door frames
- MUD room door had paint chips and the end of the hand rail wais missing on the wall beside the MUD room leaving a sharp unfinished edge

4 b) Resident room observations in Williamsburg RHA on June 25, 2014 by inspector # 105:
- Room observation for 3 residents revealed black marks and scratches through paint

on 2 of 4 bathroom walls, the closet doors were heavily scraped and the wall upon entry into the room to the left was badly damaged with plaster gouged and debris scattered onto the floor, walls outside the washroom are also damaged, the wall by the closet showed the baseboard had been damaged with a black substance and it was collecting on the floor below, minor wall damage outside of the washroom and damage to walls right and left upon entry had paint chips and the floors had light brown stains between the bed and closet

4 d) Williamsburg common area observations on June 24, 2014 by inspector # 105:
- Living Room 279 floor shows black debris in front of the TV area about 3 feet x 4 feet. Wall damage on entry of room to the right with gouges into the plaster
- Jacuzzi Room 292 outside of the door was scratched through the paint. Black debris noted in the toilet area and damage to the wall
- SPA Room 280 had a small amount of wall damage with paint chipped noted just inside the room to the left
- Dining Room upon entry to the right, the lower part of the window frame noted as scratched through the paint. Food debris noted along the top of the radiator which is also scratched through the paint. Brown drops are note along the window sill. Flooring revealed some deeper scratches in front of the servery to the first dining table

5) Beechwood RHA observations on June 24, 2014 by inspector # 105:
- SPA Room 380 door frame was scratched through the paint
- linen cupboard door was noted to be scratched through the paint (across from room 342)

6 a) Rosemount RHA observations on June 24, 2014 by inspector # 105:
- SPA Room 355 shows scratches through the paint on the door frame
- The radiator at the end of hall by stairway 3 is scratched through the paint (minor)

6 b) Resident room observations in Rosemount RHA by inspector # 522:
- Room observation for 2 residents revealed paint scrapped off the heater beneath the window and the closet door had a scrape across it, and the handle on the bathroom door was loose and there was a hole in the bathroom door. There was a large water stain noted on the bathroom ceiling by the fan and the wall to the right of the door had a scrape along it

6 c) Resident room observations in Rosemount RHA on June 24, 2014 by inspector # 563:

- Room observation for 2 residents revealed bathroom grab bar had a chipped plastered area where dry wall was repaired and the area was not sanded and repainted, and a 3 drawer dresser had drawers that did not properly fit the dresser, top and middle drawer moved in and out together, and the bottom drawer was too small for space and did not slide open

Staff interview with RPN on June 25, 2014 at 1055 hrs. confirmed the dresser drawers were in disrepair and the dresser was replaced immediately.

The Environmental Service Manager (ESM) confirmed the hand rails are in a state of disrepair and shared that the company who manufactured the hand rails no longer produces this type of hand rail and replacement parts are not available to purchase. The EMS confirmed the home is aware of the missing corners to the hand rails and a corporate plan is in place to replace all the hand rails in all RHAs. ESM shared maintenance staff removed corner hand rail pieces from lobby common areas where residents do not use the rails and replaced the corners in other parts of the home where residents are using the hand rails for mobility.

Both the EMS and a maintenance staff member shared they painted the doors to the family and dining rooms 2 months ago with an acrylic paint. The ESM shared the acrylic paint requires 7 days to cure. The painting was done so that drying is completed over night, however staff and residents continue to use the doors before the paint has had time to set creating stains and the paint is easily scraped off metal surfaces. EMS shared a new commercial grade acrylic paint will be used to repaint areas of disrepair. [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 that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident-staff communication and response system be easily seen, accessed and used by residents at all times.

Observation in the Rosemont RHA revealed the call bell system at the resident bedside worked one out of five times. This was confirmed by the Social Worker.

Observation on June 24, 2014 revealed resident was lying in bed. The resident's call bell was on the floor between the resident's bed and wall. The Director Of Care confirmed call bell was not within reach of resident.

The Director of Clinical Services confirmed the expectation is that the resident-staff communication and response system be accessible to resident's at all times. [s. 17. (1) (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 the resident-staff communication and response system be easily seen, accessed and used by residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The home's policy "Safety, Resident Abuse, Policy #RCA-LTCE-E-02 RCAM-IV-15" last revised April 2013 indicates:

"Sexual Abuse Means: Non-consensual sexual physical touching of a resident, such behaviours include but are not limited to: non-consensual touching of a sexual nature of the resident including kissing. Abuse reporting is mandatory; all staff members are required to report any abuse or allegation of abuse immediately to the Administrator/General Manager, Director of Care/Resident Services Manager or designate. The person receiving the report is to report the allegation to the provincial Ministry of Health and Long Term Care/Regional Health Authority by phoning the duty inspector immediately on the day of the report and follow up with a Critical Incident Summary or other provincially required report in keeping with the directions for making mandatory reports."

Suspicion of abuse was observed by staff and was not reported to management.

The Administrator confirmed the expectation that any suspicion of abuse is reported to the Director of Care immediately and the Director is notified via a phone call and a Critical Incident report immediately. [s. 20. (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 home's policy promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

Record review for 4 residents revealed most recent height was measured between 2009 and 2011. (563)

Resident # 2 was admitted in 2009 and had not had height a measured on admission or a height measured as of June 25, 2014. A Registered Practical Nurse and the Food Services Manager confirmed that the expectation is that the registered staff are to measure every resident's height on admission and then annually and heights are documented in Point Click Care. (213) [s. 68. (2) (e) (ii)]

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 there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure all hazardous substances are kept inaccessible to residents at all times.

On June 24, 2014 during a tour of Forest Hill secured RHA inspector observed an unlocked treatment cart in the bathroom of resident room 138. The treatment cart contained scissors and numerous prescription creams and tar shampoo.

Interview with the Registered Practical Nurse confirmed the cart should be with a registered staff member at all times. Interview with Director of Care confirmed the treatment cart should never be left unattended and unlocked.

On June 24, 2014 during a tour of Williamsburg RHA inspector observed the linen cupboard door open. This was confirmed by the Primary Care Provider. The room contained ED-Everyday Disinfectant. Interview with the PCP confirmed that the linen cupboard door should be locked at all times. Interview with the DOC confirmed the expectation is that the linen cupboard door be locked at all times.

On June 25, 2014 inspector observed a housekeeping cart which contained disinfectant in the hall outside of resident room 311 on the Rosemont RHA. Housekeeper was in resident's bathroom and did not have sight of the cart. The housekeeper confirmed she did not have sight of the cart which contained accessible chemicals.

Interview with the Director of Care confirmed the expectation is that if chemicals are not locked in the housekeeping cart that the cart must be within the housekeeper's sight at all times.

On June 30, 2014 at 1005 hrs. on the Rosemont RHA inspector observed the door to SPA room 355 was wide open. The SPA room contained Hydrofoamer Disinfectant and Isopropyl Alcohol. Inspector waited 10 minutes for staff to return to the SPA room.

Primary Care Provider confirmed that the SPA room door was left ajar and should be locked. Interview with the Director of Clinical Services confirmed the expectation is that the SPA room door be locked at all times. [s. 91.]

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 all hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to provide clear direction to staff who provide direct care to resident # 53.

The medical record review revealed that the RAI MDS Assessment indicated the need for oral care by resident or staff.

The Plan of Care does not mention mouth care, dentures or any other information concerning oral care.

The RAI Coordinator confirmed the care plan has no direction for staff who provide direct oral care.

The Director of Care shared that the expectation is for staff to provide oral care to residents after breakfast and at bedtime. [s. 6. (1) (c)]

WN #7: 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. They licensee failed to ensure that 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; 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 a record is kept of the date, the participants and the results of the conferences.

There was no conference within six weeks of admission to the home for resident # 53.

There have been two partial Care Conferences started and neither were completed. The record did not include the participants or results of the conferences. The resident and/or SMD were not given an opportunity to participate fully in the conferences.

This was confirmed by the Director of Clinical Services. [s. 27. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure staff participate in the implementation of the infection prevention and control program.

Observation of the Jacuzzi room 392 on June 25, 2014 at 1007 hrs. revealed one pair nail clippers unlabeled, two tooth brushes used and unlabeled, and one used and unlabeled bottle of hand and body lotion.

Observation in resident's bathroom revealed used and unlabeled personal care items.

Observation of SPA room 255 on June 25, 2014 at 1150 hrs. revealed one brush and one comb used and unlabeled.

The PCP Coordinator on June 25, 2014 at 1150 hrs. confirmed all resident personal items must be labeled at all times. [s. 229. (4)]

2. The licensee failed to ensure each resident admitted to the home was screened for tuberculosis within 14 days of admission.

Review of Resident # 31 clinical record revealed the resident did not receive the TB 2 Step Mantoux Skin Test Step 1 until 3 months after admission to the home.

Review of the home's Tuberculosis Disease-Screening, Detection and Management Policy Number LTCE-INF-C-08, Revised April 2014 states, "Within 14 days of admission to the home the Registered Staff will ensure that the resident has been screened for TB."

Interview with Director of Clinical Services (DCS) confirmed that resident # 31 did not receive a TB skin test within 14 days of admission. DCS confirmed the expectation is that all residents receive a TB 2 Step Mantoux Skin Test within 14 days of admission. [s. 229. (10) 1.]

Issued on this 11th day of July, 2014

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