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
Aug 29, 2014	2014_251512_0009	T-202-14	Resident Quality Inspection

Licensee/Titulaire de permis

HELLENIC HOME FOR THE AGED INC.
33 WINONA DRIVE, TORONTO, ON, M6G-3Z7

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

HELLENIC HOME - SCARBOROUGH
2411 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-4X1

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

TILDA HUI (512), NITAL SHETH (500), VERON ASH (535)

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 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, and 30, 2014.

Additional inspections related to the following LOG#'s were also completed during this inspection:
1) T-807-13, critical incident
2) T-304-14, complaint.

During the course of the inspection, the inspector(s) spoke with chief executive officer(CEO), administrator, director of care(DOC), senior clinical care coordinator, clinical care coordinator(CCC), support care coordinator(SCC), food service manager(FSM), environmental service supervisor, office manager, activation manager, registered dietitian(RD), registered nurse(RN), registered practical nurse(RPN), personal support worker(PSW), activation staff, dietary aide(DA), housekeeping aide, volunteers, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in home and resident's areas, observation in care delivery processes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
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
Safe and Secure Home
Sufficient Staffing
Training and Orientation

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. 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. (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. (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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #956 sets out clear directions to staff and others who provide direct care to the resident.

Review of the resident's plan of care revealed that there were unclear directions set out to address the resident's bladder continence needs. The resident was described as continent of both bowels and bladder when he/she was awake and alert, but was incontinent of both bowels and bladder if asleep in his/her chair. Toileting intervention during the day described that the resident was on toileting schedule.

MDS continence assessment indicated the resident is incontinent of bladder and bowel, requires toileting schedules and wears incontinent products.

Interview with a registered nursing staff and a PSW on the unit revealed conflicting information on the continence status of the resident. The registered nursing staff indicated that the resident was continent and not wearing any incontinent products.

The PSW described the resident as both incontinent of bladder and bowel and wearing incontinent briefs at all times. The interviews confirmed that the directions set out in the plan of care to staff were unclear. The resident was not able to be interviewed due to his/her cognitive status. [s. 6. (1) (c)]

2. The licensee failed to ensure that the SDM of resident #956 has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Interviews with the SDM of the resident revealed that the resident was prescribed and administered an antipsychotic medication from May 21, 2013. Resident's SDM was informed and had asked to discuss with the home's physician regarding the side effects of the medications prior to commencing the medication administration. SDM stated that no one responded back to him/her. SDM attended an annual care conference in April 2014 and raised concerns when he/she discovered that the resident had been administered the medication since May 2013.

Interview with registered nursing staff confirmed that the resident had been on the antipsychotic medication since May 2013 until May 2014 when it was discontinued. [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review revealed that resident #834 was to be showered on his/her scheduled days.

Resident and staff interviews confirmed that an identified PSW continued to give tub baths to the resident although the resident indicated that he/she preferred to take showers. The resident became upset and refused to have his/her scheduled baths on the scheduled days. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Observation conducted on June 16, 2014, at 12:00, p.m., in an identified dining room revealed that resident #001 was served pudding thick juice (125 ml), milk (250 ml), and water (250 ml). A PSW was feeding these fluids to the resident by using a spoon.

A review of the resident's diet sheet in a PSW's binder revealed that the resident was on honey consistency of fluids.

Interview with the PSW who was feeding fluids to the resident confirmed that he/she was not aware of the consistency of fluids required by the resident. He/she said that the resident was on nectar thick fluids.

Interview with the FSM confirmed that PSWs have binders indicating diet sheets with the information on resident's diet, texture and fluid consistencies in the serveries. PSW was required to refer to the diet sheets if he/she was not sure about resident's fluid consistency. [s. 6. (7)]

5. The licensee failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out, and the effectiveness of the plan of care are documented.

Record review indicated that signatures were missing from the hourly restraint monitoring record of resident #839. Signatures were missing from PSW on evening shifts for June 10, 11, 13, 16, 17, 18, 19, 20 and 23, while entries were noted missing on day shift for June 14, 15 and 24, 2014. Signatures from registered nursing staff were also noted missing for the reassessment for various shifts on June 4, 5, 6, 10, 11, 13 to June 24, 2014.

Interview with an identified PSW and registered nursing staff confirmed that the hourly restraint monitoring and reassessment per shift by registered staff were conducted. Interview with the support care coordinator confirmed that the staff on duties for those shifts should have documented on the resident's restraint monitoring record after providing the care as indicated on the plan of care. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, that the SDM of residents are provided the opportunity to participate fully in the development and implementation of the plan of care, that the care set out in the plan of care is provided to the resident as specified in the plan, and that the provision of the care set out in the plan of care our documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's plan, policy, protocol, procedure, strategy or system is complied with.

Record review revealed that the home's call bell policy dated March 2014, indicated that staff was to respond to resident's call bell within three minutes or less from the time it is initiated.

On June 18, 2014, the inspector observed resident #013 sitting in his/her room with the nasal prongs administering oxygen removed and the call bell response system in the room activated with light flashing and sound chiming. After three minutes, the inspector checked to ensure that resident's condition was stable, and stayed with the resident while activating the emergency call bell in the resident's washroom to elicit a quicker response from staff. The inspector observed that the resident waited over

eight minutes without a response from staff. The inspector walked to the nursing station, where an identified registered nursing staff was just returning from break, and informed the staff that the resident had been waiting for a response to the call bell for over eight minutes. The registered nursing staff then proceeded to the resident's room to check on the resident. The registered nursing staff confirmed that residents often waited for extended periods before call bells were answered by staff.

The inspector requested and reviewed the home's call bell reports for the period dated April to June 2014. Record review confirmed that the average wait times from resident's initial activation of the call bell to the staff response resulting in cancellation of the call bell was greater than five minutes for 60% of the time, with a resident waiting up to 16 minutes before cancellation of the call bell by a staff on one occasion. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy titled Medication administration - Insulin pen , #2.27, stated that staff must check the site of the last dose to ensure site rotation by following pre-determined site rotation protocol as per home policy.

The inspector observed on two separate medication passes that the staff did not refer to the site of the last dose prior to the administration, but instead asked each resident where they would like to have the insulin administered, and the residents chose where they wanted to receive the injection.

The home's policy titled Narcotic and controlled drugs, #2.36, stated that all entries must be made at the time the drug is removed from the container.

The inspector observed at the end of the 8 a.m. medication pass that the registered nursing staff opened the narcotic drawer and removed a fentanyl patch, then locked the drawer. The registered staff did not sign the narcotic log to indicate the removal of the drug.

Interview with the registered nursing staff confirmed that he/she did not sign the narcotic log at the time of removal from the container. The registered nursing staff stated that he/she was preparing in advance for the 10 a.m. medication pass. [s. 8. (1)] (535) [s. 8. (1)]

3. Resident #941 reported missing article of clothing after they were sent to the laundry for cleaning. The resident reported the missing items to staff and

acknowledges that the staff searched the immediate surrounding for the missing item but that it was never found. An interview with the home's support care coordinator confirmed that the staff should have completed the home's missing item form if the resident's clothing was not found.

The inspector noted that there are frequent entries of resident's missing clothing documented in the resident council minutes and in the home's concerns binder, dating back to 2011. [s. 8. (1) (a),s. 8. (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 the home's policy on staff's timely response to call bells, Insulin site rotation, and narcotic and controlled substance's entry into the narcotic count sheet to be made at time of administration, are complied with, to be implemented voluntarily.

WN #3: 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 that the home is equipped with a resident-staff communication and response system that is easily accessed and used by residents, and is on at all times.

Observation made on June 20, 2014, at 2:00 p.m., and 2:10 p.m., on an identified floor indicated that residents #839 and #867 were sitting in their wheelchairs in their respective rooms. The residents were placed about two to three feet away at the end of their beds, and the call bells were pinned to the bed linen at the head of the beds. The call bells were not within reach for these two residents who were totally dependent on mobility and transferring and were not able to wheel themselves to the bed to activate the call bells.

Interview with a PSW on duty confirmed that the residents should have been placed closer to the beds and the call bells should have been made accessible to the residents. [s. 17. (1) (a)]

2. The inspector observed on June 19, 2014, at 1:30 p.m., in two identified residents' rooms that the bedside call bells were not functional, and in one identified resident's room, the call bell in the washroom was not functional.

Interview with an identified registered nursing staff indicated that he/she was not aware of the non-functional call bells, and confirmed that this should be reported to maintenance staff for repair.

Interview with the support care coordinator confirmed that after the inspector notified the home about the non-functional call bells, he/she checked all call bells in the home with the maintenance staff and repaired non-functional call bells in another eight resident's rooms. [s. 17. (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 the home is equipped with a resident-staff communication and response system that is easily accessed and used by residents, and is on at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee within 10 days of receiving the advice, responds to the Residents' Council in writing.

Interview with a representative of the Residents' Council revealed that the home did not provide any written responses to the Residents' Council within 10 days of receiving the concerns.

Interview with staff confirmed that the home usually documents concerns and action plans and post them on the boards on each unit within 3 days of the Residents' Council meeting. The home has not been providing responses to the Residents' Council in writing. Concerns and action plans are communicated verbally with the residents at the next Residents' Council meeting by the assistant of the Residents' Council. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee, within 10 days of receiving the advice, responds to the Residents' Council in writing, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to ensure that all areas where drugs are stored are kept locked at all times, when not is use.

On June 19 and 20, 2014, during the medication passes on two identified units, the inspector observed that the medication carts were left unlocked while the registered staff left the area to administer medication to residents in the dining room or inside residents' rooms.

The inspector also observed that on two separate occasions the door of the medication on an identified floor was left open and unattended while a registered nursing staff was observed documenting on the computer at the nursing station with his/her back to the door of the medication room. The inspector also observed that the emergency stock medication box was sitting on the counter top of the nursing station on the same floor, and that it was left unlocked and no registered nursing staff were observed near by at the time. [s. 130. 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 steps are taken to ensure that all areas where drugs are stored are kept locked at all times, when not is use, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that training related to continence care and bowel management, the application, use and potential dangers of restraining using physical devices, and abuse recognition and prevention are provided to all direct care staff in 2013.

Record review revealed that 31% of direct care staff received the training in continence care and bowel management in 2013.

Interview with the DOC confirmed that the continence care training was not provided to all direct care staff in 2013. [s. 221. (1) 3.]

2. Record review revealed that 32.14% of staff had received training in the application, use and potential dangers of restraining using physical devices in 2013.

Interview with the DOC confirmed that the restraint training was not provided to all staff who apply physical devices or monitor residents under restraint. [s. 221. (1) 5.]

3. Record review revealed that 27% of staff who provided direct care to residents completed the training related to abuse recognition and prevention in 2013.

Interview with the DOC confirmed that the abuse training was not provided to all direct care staff in 2013. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that training related to continence care and bowel management, the application, use and potential dangers of restraining using physical devices, and abuse recognition and prevention is provided to all direct care staff annually, to be implemented voluntarily.

WN #7: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

The inspector observed on three separate occasions during medication passes that the registered nursing staff did not clean his/her hands before or after each medication administration.

Interview with the DOC confirmed that the home's expectation was that staff clean their hands between each resident contact. [s. 229. (4)]

2. Observations made on June 18, 2014, on an identified floor revealed that unlabeled personal care items including denture cups, shaving cream, shampoo, mouthwash, soap and body lotion, tooth and hair brushes were noted in six identified residents' shared bathrooms. Rinse basins were being left on the counter or on the floor in three identified shared bathrooms. One unlabeled bedpan was noted on the floor inside one identified resident's room.

In one identified shared room, the resident was on contact precautions. There were gowns kept in the lower drawer of the isolation cart outside the door, but no gloves nor hand sanitizer were found. The sign posted inside the resident's room stated: "wear

gloves, gowns, hand washing required". Body lotion and other toiletries were found on the floor in the resident’s room.

Observation made on June 18, 2014, on an identified floor revealed that unlabeled personal care items including denture cups, tooth and hairbrushes were found in two identified residents’ shared bathrooms. Unlabeled rinse basins were also found on the counter of these bathrooms. [s. 229. (4)]

3. Observation made on June 17, 2014, at 12:30 p.m. on an identified floor noted two unlabeled used hair combs on a care cart inside the spa room. During the same observation, unlabeled personal care items including denture cup, tooth and hair brushes were found in three identified residents' shared bathrooms.

Interview with PSW confirmed that those personal care items should have been cleaned and labeled with individual resident's name. [s. 229. (4)]

4. The licensee failed to ensure that each resident admitted to the home was 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.

Record review revealed that resident #952 admitted in February of 2013, received tuberculosis (TB) 2-step Mantoux skin test 16 days after admission.

Interview with the DOC confirmed that the TB skin test should have been conducted for the resident within 14 days of admission. [s. 229. (10) 1.]

5. The licensee failed to ensure that residents were offered immunizations against diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Interview with registered nursing staff revealed that the home did not offer diphtheria immunization to residents. An interview with the DOC confirmed that the home did not offer diphtheria immunization to residents. The DOC stated that pneumococcus and tetanus vaccines were routinely offered to residents and given if ordered by the physician. [s. 229. (10) 3.]

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 all staff participate in the implementation of the infection prevention and control program, that each resident admitted to the home is screened for tuberculosis within 14 days of admission, and that residents are offered immunizations against diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #8: 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 are kept clean and sanitary.

Observation made on June 16, 2014, at 10:15 a.m., noted a sofa with food stains on a ground floor sitting area, and a chair with stains on an identified floor. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home furnishings are maintained in a safe condition and in a good state of repair.

Observation made on June 16, 2014, at 10:30 a.m., noted a chair in a poor condition with fabric worn off at the arm rest area.

Interview with the environmental service supervisor identified the need to clean and sanitize the above mentioned sofa and chair, and the need to replace worn off fabric of the identified chair. [s. 15. (2) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all fluids in the food production system are prepared using methods to, preserve taste, nutritive value, appearance and food quality.

Observation conducted on June 16, 2014, at 12:00 p.m., in the dining room of an

identified floor revealed that resident #001 was served with pudding thick cranberry juice (125 ml), water (250 ml) and milk (250 ml). PSW was feeding fluids to the resident using a spoon.

Review of a diet sheet revealed that the resident was on honey thick fluids.

Review of a document provided to the PSWs to prepare thickened fluids in the dining room titled "Tips for the Thickening Fluids" revealed that the tips sheet provides the amount of thickener to use to prepare only 125 ml of juice, milk and hot beverages at nectar, honey and pudding consistencies. The document did not provide the amount of thickener to use to thicken 250 ml of milk and water at nectar, honey and pudding consistencies.

Interview with the PSW, confirmed that he/she was not aware that resident was on honey thick fluids and said the resident was on nectar thick fluids. After looking at the diet sheet, the PSW realized that the resident was on honey thick fluids. He/she confirmed that he/she followed the recipe for thickened fluid while preparing thickened fluid for the resident to make it at honey consistency. He/she used 2 scoops of thickener to make 125 ml honey thick juice, 250 ml honey thick milk and 250 ml honey thick water for the resident.

Interview with the FSM confirmed that fluids should be thickened by using a recipe provided in the binder. The recipe currently provided in the binder did not contain enough information to thicken 250 ml of water and milk at nectar, honey and pudding consistencies.

The amount of thickener used by the PSW to thicken 125 ml of juice, 250 ml of water and milk was not accurate and use of an inadequate amount of thickener can affect the taste, nutritive value and the quality of the thickened fluids. [s. 72. (3) (a)]

2. The licensee failed to ensure that the staff of the home comply with the home's policy on cleaning schedules.

A review of a home's policy titled Cleaning and sanitizing cleaning schedules, #DS D-10-05, dated July 01, 2010, revealed that the dietary cleaning schedule is a part of the dietary staff's job routine. The policy stated that dietary staff must sign off on their schedules after they complete their assigned duties. To ensure compliance by dietary staff, the cleaning schedule will be checked at random at least weekly by the FSM.

A review of a daily cleaning schedule for dish room area for June, 2014, revealed that staff did not sign the schedule from June 2 to June 23, 2014.

Interview with the FSM confirmed that staff should follow the dish room area cleaning schedule and sign off once the cleaning is completed. FSM stated that he/she was very busy and was not able to pay attention to the schedule, and did not have the opportunity to talk to the dietary staff about schedules not being signed off. [s. 72. (7) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79

(3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the copies of the inspection reports for the past two years are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observation conducted on June 16, 2014, at 10:00 a.m., revealed that MOHLTC inspection reports for the past two years were kept inside a binder placed in front of the reception. The inspector did not see any sign or note for residents, families or visitors indicating availability and location of MOHLTC inspection reports.

An interview with the administrator confirmed that the inspection reports for the past two years were not posted. [s. 79. (1)]

2. A review of the MOHLTC inspection reports for the past two years from the binder revealed that page #2 and #3 were missing from the inspection report dated January 14, 2014.

Interview with the office manager confirmed that pages might be missing because of a double-sided photocopying mistake and he/she will replace a new copy of the report with all pages. [s. 79. (3) (k)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for residents care.

Record review revealed that the licensee has a written policy titled Abuse or suspected abuse of a resident, #MRC-G-10.00. The policy defined abuse and neglect, however the policy does not address the issue of neglect throughout the document. The content of the policy does not address training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for residents care. [s. 96. (e)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Record review conducted revealed no evidence of an evaluation having been conducted for 2013.

An interview with the DOC confirmed that the home did not complete an evaluation of the zero tolerance of abuse and neglect of resident policy in 2013. [s. 99. (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a staff member who is not otherwise permitted to administer a drug has been trained by a member of the registered nursing staff in the administration of topicals.

Staff interviews confirmed that registered nursing staff believed PSWs were provided training in the administration of topical medication by the support care coordinator and that PSWs were competent to apply topical cream and ointments without further training or supervision.

An interview with the support care coordinator confirmed that PSWs were not provided training in the application of topical creams and ointments, and that registered nursing staff were to provide hands-on training and supervision to ensure safe application. [s. 131. (4)]

2. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

Interview with resident #014 indicated that the resident was on self medication.

Record review revealed that there was no order for the resident's self- medication written by the home's physician, no consent signed by the resident, and the self-medication assessment was not conducted.

Interview with an identified registered nursing staff confirmed that the resident did not have a physician's order to self-medicate, did not sign a consent for self-medication, and that the medication self-assessment record was not completed. In addition, the resident did not have a locked drawer in his/her room to store the medication. [s. 131. (5)]

WN #14: 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. (5) The licensee shall ensure,
(a) that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective; O. Reg. 79/10, s. 136 (5).
(b) that any changes identified in the audit are implemented; and O. Reg. 79/10, s. 136 (5).
(c) that a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 136 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective, that any changes identified in the audit are implemented, and that a written record is kept of everything provided for as above.

Record review conducted revealed no evidence of an audit having been conducted for 2013.

An interview with the DOC confirmed that the drug destruction and disposal audit was not completed for 2013. [s. 136. (5)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that at least annually, the program training and orientation program is evaluated and updated in accordance with evidence-based practise and, if there are none, in accordance with prevailing practises.

Record review was conducted on a document provided by the DOC related to the evaluation of the training and orientation program. The one page document consisted of the minutes from a meeting titled 'staffing committee minutes' with a single entry at the bottom of the page stating that there were new hires and that they had completed three orientation shifts.

Interview conducted with the DOC confirmed that there was no formal evaluation conducted for the home’s training and orientation program. The DOC stated that the one page document was the only documentation available related to the training and orientation evaluation. [s. 216. (2)]

Issued on this 1st day of October, 2014

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