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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Sep 2, 2014	2014_159178_0018	T-109-14	Resident Quality Inspection

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue, Woodbridge, ON, L4L-1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court, Woodbridge, ON, L4L-9T3

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

SUSAN LUI (178), BARBARA PARISOTTO (558), NATASHA JONES (591), VALERIE JOHNSTON (202)

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): August 13, 14, 15, 18, 19, 20, 21, 22, 25, 2014.

The following Critical Incident Intakes were inspected concurrently with this RQI:
T-476-13, T-343-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Resident and Family Services, Director of Support Services, registered staff, personal support workers (PSWs), registered dietitian (RD), dietary aides, pharmacist, recreation assistants, housekeeping employees, maintenance employee, residents, residents' families.

During the course of the inspection, the inspector(s) observed resident home areas, observed resident care, reviewed resident health records, reviewed the home's records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
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. 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 ensure that resident #14's right to have his/her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, was respected.

Record review and staff interviews confirm that on an identified date, the health record for resident #14 was misplaced. The resident's home area and the entire building was searched, but the record was not found. Video surveillance of the resident's home area was reviewed, and no one was observed leaving the area with the health record. A new security lock was subsequently added to the entrance to the nursing station on the resident's home area to limit access by wandering residents. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, is respected, to be implemented voluntarily.

WN #2: 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 ensure that the resident's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of resident #3's plan of care revealed contradictory directions to staff regarding administration of protein powder.
Record review confirmed that resident #3's care plan and medication administration record (MAR) instruct the staff to provide the resident with two scoops of protein at breakfast and one scoop at supper (three scoops of protein per day). The physician's order states that the resident should receive two scoops of protein powder at breakfast, one scoop at lunch, and one scoop at supper (four scoops of protein per day).

Interview with a full time registered staff member, and review of the resident's MAR confirm that the resident was receiving four scoops of protein on the days that the staff member worked.

After the inspector pointed out the contradictory directions in the plan of care, the order was revised by the registered dietitian (RD). [s. 6. (1) (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 resident's written plan of care sets out clear directions to staff and others who provide direct care to the resident, 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that is available at each bed location used by residents.

On August 13, 2014, it was observed that a resident-staff communication and response system was not available at the bed location used by resident #5. An interview with the administrator confirmed that resident #5 does not have a call bell available at the spot where, as per the family's request, his/her bed is currently located. Therefore, while in bed, resident #5 is provided with resident #6's call bell, as resident # 6 is not capable of using the call bell. Staff interviews and record review confirm that resident #5 rings the call bell for resident #6 when he/she requires assistance. [s. 17. (1) (d)]

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 available at each bed location used by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #6's plan of care identified the resident as having frail skin and altered skin integrity. A review of the resident's progress notes for January-August 2014, indicated that the resident had been identified with altered skin integrity on various parts of the body, on 10 different dates.

Interviews with the DOC, ADOC and an identified RPN, confirmed that resident #06 did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for the resident's altered skin integrity noted above. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

Staff interviews and record review indicated that from March-August 2014, resident #6 had altered skin integrity, including ongoing skin tears and pressure wounds, identified on various parts of the body on 14 different dates.

An interview with an identified RPN indicated that the resident had ongoing altered skin integrity issues, however, the resident had not been referred to the dietitian. The RPN indicated that because the resident has been taking protein powder at meals for the past year, a dietitian assessment was not necessary. An interview with the dietitian indicated that he/she was unaware that the resident was exhibiting altered skin integrity and therefore the resident had not been assessed or the care plan changed. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Resident #6's plan of care identified the resident as having frail skin and ongoing altered skin integrity issues. A review of the resident's progress for January-August 2014, revealed that on March 08, 2014, the resident had a skin tear, and as of August 20, 2014, the resident has a stage II pressure ulcer in the same location. The progress notes indicated that the resident's stage II pressure wound had not been assessed weekly between March 24 and May 09, 2014.

Record review indicated that the resident experienced skin tears on April 25 and June 2, 2014, and a wound on July 22, 2014. No further assessments of these wounds were present in the resident's record.

An interview with an identified registered staff member indicated that residents exhibiting altered skin integrity are to be assessed weekly, however the weekly assessments are not always completed. The registered staff member confirmed that the resident did not receive a weekly skin assessment of the wounds indicated above. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds:
-receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
-is assessed by a registered dietitian who is a member of the staff of the home, and has any changes made to the plan of care related to nutrition and hydration been implemented
-is reassessed at least weekly by a member of the registered nursing staff, 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 has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On afternoon of August 18, 2014, on the 5th floor, the inspector observed the medication cart parked in the hall beside the nursing station. Several residents were sitting in the vicinity of the medication cart. The inspector attempted to open one of the drawers on the medication cart and found that none of the drawers were locked. Various medications were in the unlocked drawers. The nurse was not within the vicinity of the medication cart. Two minutes later, the nurse came out of the dining room, pushing a resident in a wheelchair. The inspector showed the nurse that the cart was unlocked by opening two of the drawers. The nurse confirmed that the cart should be locked at all times, but that he/she was called into the dining room and stepped away from the cart without locking it. The nurse then locked the cart. Interview with the DOC confirmed that the medication cart should remain locked at all times when not in use. [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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #6: 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 kept clean and sanitary.
Observations on August 18, 19, and 20, 2014 revealed the following housekeeping concerns:
-in the 4th floor dining room, food debris and staining was noted on the windowsill and the wall nearest to the servery, and orange staining was noted on the window blind nearest to the servery.
-in the 4th floor shower room, soap debris was observed on the stainless steel dividing wall beside the shower stall.
-the footrest cover on the right side of resident # 4's wheelchair was noted to be soiled with food.
-the plush chair owned by resident # 5 and kept in the resident's room was noted to be stained with apparent food stains.
-the wheelchair seat cushion for resident # 5 was noted to be soiled with food on August 18 and 19, 2014.
Interviews with front line nursing and housekeeping staff confirmed that there are schedules in place for routine cleaning of the home, its furnishings, and resident's ambulation equipment, and that in between the routine cleaning these items should be spot cleaned by staff if they are noted to be soiled.
Interview with the home's Director of Support Services revealed that the cleaning of residents' own furniture is not completed routinely by the home's staff, but that staff will clean a resident's furniture if it is noted to be soiled.

All of the above noted housekeeping concerns were rectified prior to the end of the inspection period. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director with respect to an alleged incident of abuse of a resident, included the names of any staff members or other persons who were present at the incident.

Record review revealed that the critical incident report #2947-000017-13 submitted August 9, 2013, and amended September 25, 2013, failed to include the name of the staff member involved in an alleged incident of staff to resident abuse. The Administrator confirmed this information was not included in the report. [s. 104. (1) 2.]

Issued on this 3rd day of September, 2014

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

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