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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 3, 2014	2014_278539_0024	H-001338-14	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE MISSISSAUGA INC.
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

SPECIALTY CARE MISSISSAUGA ROAD
4350 MISSISSAUGA ROAD MISSISSAUGA ON L5M 7C8

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

VALERIE GOLDRUP (539), LALEH NEWELL (147), LAURA BROWN-HUESKEN (503), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 7, 8, 9, 10, 14, 15, 16, and 17, 2014

The following Critical Incident Inspections were completed during this inspection: H-000719-14, H-000783-14, H-000850-14, H-000855-14, H-001269-14, and H-001279-14. The following Complaint Inspection was completed during this inspection: H-000679-14.

During the course of the inspection, the inspector(s) spoke with Director of Resident Programs, Dietician, Director of Care, Executive Director, Personal Support Worker (PSW) Manager, Associate Directors of Care, Food Service Supervisor, registered staff including Registered Nurses and Registered Practical Nurses, personal support workers (PSW), dietary staff, housekeeping staff, residents and family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **9 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The home did not ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A)During resident interviews in Stage 1 of the Resident Quality Inspection (RQI) on October 9, 2014, when Resident #037 was asked if they had ever been treated roughly by staff they described an event that had occurred on the night shift in September, 2014. The resident described having to wait to be changed and then being treated roughly. Progress notes described their recount to staff of how the Personal Support Worker "pulled the soaker pad hard [enough]that if not for the siderail I would have been on the floor". The Director of Care provided a copy of the investigation notes for the incident. It was confirmed with the Director of Care that the resident had waited to be changed and that the Director of Care reviewed the proper provision of care with the PSW.(539)

B)Family members of residents #302 and #303 described to management how a PSW spoke in a loud manner to their family members. As follow-up to the Critical Incident submission, these concerns were investigated by the home and the Administrator spoke to the PSW regarding their behaviour. The PSW received discipline and was required to undergo training to improve their customer service and communication techniques. This was confirmed with the Director of Care.(539)

C)When interviewed by staff during a random interview as part of the home's quality improvement process, Resident #301 described how on the night shift in June, 2014 a PSW refused to toilet them, did not provide a blanket and removed the call bell from their reach. The investigation notes for the incident confirmed that the resident had not had

the call bell within reach. The employee received discipline and the Director of Care reviewed the proper provision of care with the PSW. This was confirmed with the Director of Care.(539)

D)During resident interviews in Stage 1 of the Resident Quality Inspection (RQI) on October 7, 2014, resident #020 stated that they did not feel like they were provided privacy during their bath. A registered staff and PSW confirmed that the privacy curtain was drawn when a resident had a bath but that other staff may enter the area to obtain lifting equipment. On the morning of October 17, 2014, at 0945 hours, inspector #107 observed a staff member enter the bathtub area when a resident was receiving a bath. Registered staff confirmed there was no sign available to be placed on the door to identify that a resident was in the bath and not to disturb them.(539)

E)During resident interviews in Stage 1 of the Resident Quality Inspection (RQI) on October 8, 2014, resident #003 shared with the inspector that they activated the call bell for assistance with toileting a few weeks ago, a Personal Support Worker (PSW) acknowledged the request and informed them that another PSW would be in to assist them shortly; however, the resident had to wait for a long time before assistance was provided.

Resident #003 was not treated with courtesy and respect. Interview with the resident on October 15, 2014 confirmed that they waited for approximately an hour and half on the toilet before assistance was provided. The resident stated that this caused their buttocks and legs to become sore due to the prolonged sitting on the toilet while waiting for staff to assist them with toileting. The resident also stated that when the PSW did arrive to assist them, the PSW raised their voice and argued with them regarding the length of time that the resident indicated they had been waiting for assistance, which made the resident very upset.

Review of the clinical record and home's investigation notes, indicated that the home initiated an immediate investigation and discipline was issued to the PSW involved.(147) [s. 3. (1) 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 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that resident #037 was reassessed and their plan of care revised when the resident's care needs changed in relation to the resident's dentures.

On August 26, 2014, progress notes written by a Denturist identified the resident was concerned that they were unable to chew hard food items with their dentures. A referral to the Registered Dietitian was not completed related to the identified concerns and there was no evidence that the resident was reassessed or their plan of care revised in relation to the mouth pain and chewing difficulties between August and October, 2014.

The Registered Dietitian reviewed the resident on October 9, 2014 and stated "no problem with current diet was reported." During interview, the Registered Dietitian stated they were not aware of the resident's concerns with chewing. In October, 2014, the resident had a choking incident (pork chop) in the dining room that required suctioning to dislodge the item.

During interview, the resident stated they had been having difficulty chewing their food for a couple of months because their dentures did not fit and they had mouth pain. The resident also stated they had been restricting their diet and avoiding certain foods due to not being able to chew them and felt the chewing problem was affecting their ability to gain weight. The resident was less than their target weight range. Documentation did not reflect that the concerns were followed up with the resident and that the problem was assessed with a plan of action to address the resident's concerns with chewing difficulties until after the choking incident. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance , to be implemented voluntarily.

WN #3: 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 did not ensure that the home's Missing Resident Laundry policy was complied with.

The home's Missing Resident Laundry policy #XII-K-20.50, revised April 2011, directed personal support workers to report missing personal clothing to the laundry staff using the Missing Laundry Form. Interviews with PSWs and the PSW Manager indicated that when items were missing that laundry was notified verbally in person or via telephone. The laundry staff confirmed that missing items were not reported using the Missing Resident Laundry form. Three resident's items were reported to be missing and the Missing Resident Laundry form was not located for the items. [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 be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been approved by
i. a physician
ii. a registered nurse
iii. a registered practical nurse
iv. a member of the College of Occupational Therapists of Ontario
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

A)The plan of care for resident #033 stated the following: "Bed Mobility: Requires one

staff extensive assistance to get to and from lying and sitting position and to move from side to side. Uses bed rails for bed mobility". It also stated "PASD: Put down both short rails when in bed. Resident stated [they feel] safe when bed rails are in place". The Director of Care confirmed that the bed rail assessments were completed on a paper form to determine if the bed rails were being used as a PASD and signed by the registered staff. Registered staff could not locate the paper copy of the bed rail assessment form. The registered staff confirmed the form should have been completed upon the admission of the resident.

B)The plan of care for resident #020 stated the following: "Bed Mobility: Two long side rails raised as per resident's request and also as PASD to prevent resident from rolling out of the bed, for bed mobility and comfort. Feb 19, 2013 - resident requesting one bedrail pad for comfort and security and to avoid [their] leg from becoming caught in the siderail. May 31st, 2013 second bedrail pad provided". The Director of Care confirmed that the bed rail assessment was completed on a paper form to determine if the bed rails were being used as a PASD and signed by the registered staff. Registered staff could not locate the paper copy of the bed rail assessment form. The registered staff confirmed the form should have been completed upon the admission of the resident. [s. 33. (4) 3.]

2. The licensee did not ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if:
- The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A)The plan of care for resident #033 stated the following: "Bed Mobility: Requires one staff extensive assistance to get to and from lying and sitting position and to move from side to side. Uses bed rails for bed mobility". It also stated "PASD: Put down both short rails when in bed. Resident stated [they feel] safe when bed rails are in place". An Associate Director of Care confirmed that there is no specific consent signed by the resident or the substitute decision maker for the use of bed rails as a PASD.

B)The plan of care for resident #037 stated the following: "Bed Mobility: PASD: Put down two short rails when in bed at all times for safety and bed mobility". An Associate Director of Care confirmed that there is no specific consent signed by the resident or the substitute decision maker for the use of bed rails as a PASD.

C)The plan of care for resident #020 stated the following: "Bed Mobility: Two long side

rails raised as per resident's request and also as PASD to prevent resident from rolling out of the bed, for bed mobility and comfort. Feb 19, 2013 - resident requesting one bedrail pad for comfort and security and to avoid [their] leg from becoming caught in the siderail. May 31st, 2013 second bedrail pad provided". An Associate Director of Care confirmed that there is no specific consent signed by the resident or the substitute decision maker for the use of bed rails as a PASD. [s. 33. (4) 4.]

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 be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #032 was provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible at the observed lunch meal October 16, 2014.

The resident's plan of care required, "One staff provide physical assistance to eat by placing food in resident's hand and also on fork or spoon. Staff to assist in guiding [resident's] hand to the resident's mouth with all food and fluids. Staff also provide assistance with set up i.e. cut up food for res and open packages. [Resident] also uses lip plate to aid in self-feeding." The resident had difficulty finding the food on their plate and finding the utensils to facilitate eating. The resident was not assisted by staff during the observed meal. A family member assisting another resident in the dining room provided assistance to the resident. [s. 73. (1) 9.]

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 be implemented voluntarily.

WN #6: 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 did not ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

On October 7, 2014, the call bell at the bedside of resident #014 was found to be non-functional. A PSW verified that the call bell was not functional and replaced the call bell cord with a second call bell cord that was on the resident's bedside table. The PSW hypothesized that the call bell cord had been replaced by the resident; however, was unsure why a second cord was in the resident's room or how it may have been obtained by the resident. [s. 17. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to resident #037 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The resident experienced a choking incident in the dining room in October, 2014 and progress notes after the incident stated to trial a minced diet. Documentation in the resident's health record did not reflect if the diet was initiated, for how long, the resident's response or acceptance of the diet, or if the resident had difficulty with the new texture. The resident stated they had tried the minced diet for a short period but they did not like it and it was discontinued. Documentation did not reflect that the diet was trialled or discontinued, any discussion with the resident about the acceptance of the diet, risks of not following the diet or action plan while waiting for the Dietitian referral to be completed.

B) The resident was assessed by the Denturist on August 26, 2014; however, the note did not reflect the outcome of the visit and if action was taken to address the resident's chewing concerns or pain. Documentation by the staff of the home did not reflect the conversation held with the Denturist about the outcome of the visit and the resident's response to the visit. Staff confirmed there was some discussion; however, this was not documented. [s. 30. (2)]

WN #8: 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 did not ensure that resident #037, who had altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On July 31, 2014 the progress notes identified a "lesion on buttocks. Lesion looks like a blister, 1.2 x 0.4 cm in size, mild redness around the area. Resident denied pain even during palpation. Dressing applied as per protocol." The blister was also noted August 15 and 20, 2014;however, an assessment using a clinically appropriate assessment instrument was not completed for the lesion. Registered staff confirmed that an assessment of the blister was not completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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).

Findings/Faits saillants :

1. The licensee did not ensure that all foods were served using methods that preserved taste, appearance and food quality at the lunch meal October 7, 2014 and breakfast meal October 8, 2014.

Residents #019, #021, #200, and #201, had their texture modified meals mixed together on the spoon or on the plate. Some of the meals were completely stirred together. The residents were unable to voice their preferences to the inspector. Documentation in the residents' plans of care did not indicate this was a preference for any of the identified residents. The practice of mixing texture modified menu items together altered the taste, appearance and food quality of the meal. [s. 72. (3) (a)]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.