Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 20, 21, 25, 26, 29, Sep 23, 2011	2011_070141_0015	Critical Incident

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with The acting Administrator, Assistant Directors of Nursing, Resident Assessment Instrument (RAI) Coordinator, registered nursing staff, and personal support workers, and resident.

During the course of the inspection, the inspector(s) Reviewed Residents' records, homes investigation notes, homes policies and procedures for transferring of residents, catheter care, documentation, and resident assessments.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. An identified resident was not reassessed for pain at the time of residents expression of a new pain. The resident started to complain of pain after an identified fall. An assessment to identify the cause of the new pain,which identified a new injury, was not completed for 4 days post fall. s.6.(10)b
2. The care set out in an identified resident' s plan of care was not provided as specified in the plan. The resident's plan of care identified the resident was totally dependent on staff for toileting and directed staff to use a ceiling lift for transfers and a mechanical lift for on and off the toilet with 2 staff present for all transfers. The resident was transferred from wheelchair to the toilet using a sit/stand lift with only one staff present. The home management staff confirmed that the direction to use a mechanical lift and lift logo at the resident's bed would direct staff to use a hoyer lift. s.6.(7)
3. The care set out in an identified resident's plan of care was not provided as specified in the plan. The resident's plan of care identified the resident as non weight bearing and directed staff to use a hoyer mechanical lift with 2 staff present for all transfers. The resident was transferred from their wheelchair to the toilet and from toilet to bed using a sit/stand lift with only one staff present. The plan of care identified that one staff was to stay with the resident throughout the entire process of toileting to ensure the resident did not fall. The resident was left unattended on the during toileting and was not able to be observed at all times. s.6.(7)
4. An identified resident was not assessed and plan of care revised at the time of of care needs change. The resident had an indwelling foley catheter inserted. An assessment of the urinary output against the resident fluid intake at the time of insertion or during the following 2 shifts was not completed. An assessment was not completed for bladder fullness, or the urinary catheter patency. The resident's plan of care was not updated to identify the indwelling catheter had been inserted and it did not identify the need to measure and record the resident's urinary output each shift as per the home's policy and procedure "Catheter Care - Indwellling" (VI - E - 10.10. s.6(10)(b)
5. An identified resident's written plan of care did not set out clear direction to staff and others who provide direct care to the resident. The resident had a history of frequent urinary tract infections and urosepsis but the plan of care did not identify the risks or strategies to address them. 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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements
Specifically failed to comply with the following subsections:

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 action taken with respect to an identified resident related to their continence care including assessments, reassessments, interventions and the resident's response were documented.
The resident had an indwelling foley catheter inserted. Documentation at the time of the procedure was incomplete related to assessment of patency, urinary output volume or quality of the urine. r.30(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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The nursing staff did not use safe transferring devices and techniques when assisting an identified resident from wheelchair to the toilet. The resident was transferred using a sit/stand lift with one staff person present. The resident plan of care directed staff to use a hoyer lift. The home policy "Zero Lift Policy" (V-E-30.00) states 2 staff must be present for all transfers of residents using a mechanical lifts. r.36
2. The nursing staff did not use safe transferring device and techniques when assisting another identified resident from wheelchair to toilet and from toilet to bed. The resident was transferred using a sit/stand lift with one staff person present. The resident plan of care directed staff to use a hoyer lift for transferring. The home policy "Zero Lift Policy" (V-E-30.00) states 2 staff must be present for all transfers of residents using a mechanical lifts. r.36

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 O.Reg 79/10, s. 24. 24-hour admission care plan
Specifically failed to comply with the following subsections:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a 24-hour admission care plan was developed for an identified resident and communicated to direct care staff within 24 hours of the resident's admission. The resident did have a 24 hour assessment completed at the time of her admission but there was no interdisciplinary care plan developed to direct staff in the care of the resident. The home's policy "Resident Assessment" (VII=D-40-00) states on the Resident Assessment Grid that the initial care plan is to be completed within 24 hours with the 24-hour initial Admission Assessment. The Assistant Director of Care and RAI Coordinator confirmed that only the 24-hour Initial Admission Assessment tool is completed at the time of resident admission. r.24(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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs
Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. On Cottage Home Area a medication cart was observed in hallway on July 18, 2011 outside dining room. The medication cart was unlocked and unattended from 11:36 to 11:42 hours. Residents were observed in the hallway at that time. r.129 (1)

WN #6: 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 subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident was cared for in a manner consistent with her needs. The resident was transferred from a wheelchair to the toilet and from the toilet to their bed by a sit/stand lift with only one Personal Support Worker (PSW) present. The resident's plan of care identified the resident was to be transferred by a hoyer lift with 2 staff present.
The resident was left unattended on the commode over the toilet with no staff present in the bathroom. The resident's plan of care states one person needs to stay with the resident throughout the entire process of toileting to ensure that they do not fall.
The resident sustained injuries while left unattended. Following the incident the registered nursing staff were not notified immediately of the injuries prior to transfer to bed causing a delay in treatment. s.3.(1)4
2. The licensee failed to ensure that an identified resident was cared for in a manner consistent with their needs. The resident was transferred from a wheelchair to the toilet by a sit/stand lift with only one PSW present. The resident's plan of care identified the resident needed a hoyer or ceiling lift for transfers with two staff present.
During the transfer the resident slid in the sit/stand lift. The resident, as a result sustained injury and change in level of care needs. s.3.(1)4

Issued on this 2nd day of September, 2011

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