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
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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
Nov 17, 2014	2014_201167_0025	H-001481-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

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

MARILYN TONE (167), DARIA TRZOS (561), LAURA BROWN-HUESKEN (503), MELODY GRAY (123)

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): November 4, 5, 6, 7, 12, 13, 14, 2014

The following inspections were completed simultaneously with this inspection, critical incident inspections H-000737-14, H-001438-14, H-001408-14 and complaint inspection H-000421-14. Non-compliance found during these inspections will be included in this report. A follow up to previously issued orders H-000379-14, H-000398-14 and H-001156-14 will be completed during this inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Resident Care (DRC), registered staff, personal support worker staff (PSWs), activation staff, Housekeeping staff, Housekeeping Supervisor, Social Worker, managers of resident care, Supervisor of Nutrition Services, Registered Dietitian, dietary aides, identified residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care and dining service, reviewed the health files for identified residents, relevant policies and procedures, cleaning schedules and food temperature logs, employee files, minutes from meetings and any relevant investigation notes completed by the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care for resident #002 was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
i) Resident #502 was admitted to the home in 2014.
ii) The admission Resident Assessment Protocol (RAP) for the resident dated as completed in September 2014 indicated the following;
Resident #502 was wandering into other residents' rooms, displayed inappropriate voiding behaviours, displayed inappropriate behaviours and remarks towards female staff and resisted care. Staff were to monitor the resident in a specified area and provide two staff for care when required.
iii) During the admission care conference in 2014, it was noted that the resident's inappropriate behaviours were discussed with the family and a trial of a new medication was suggested. It was also noted that the resident was resistive to care and toileting, required two staff extensive assistance for activities of daily living, paced, wandered, was exit seeking and was anxious and agitated.
iii) A review of the progress notes for resident #502 confirmed that the resident displayed the following behaviours over a three month period in 2014; inappropriate behaviours toward female staff on seven documented occasions, wandered into co-resident's rooms on five documented occasions, regularly wandered the unit, was noted to be resistive to care, displayed inappropriate behaviours related to continence management and on one occasion attempted to flush a towel down the toilet.
iv) PSW staff interviewed confirmed that the resident displayed these behaviours.
v) A review of the document that the home refers to as the care plan related to responsive behaviours and confirmed by the Resident Care Co-ordinator to be the most current care plan revealed that it did not include identification of the resident's wandering behaviours, inappropriate behaviours towards female staff, resistance to care, inappropriate behaviours related to continence, agitated behaviour or their attempt to flush a towel down the toilet. [s. 26. (3) 5.]

2. The licensee did not ensure that the plan of care for resident #006 was based on, at a minimum, interdisciplinary assessment of the resident's special treatments and interventions.
i) During observation of resident #006 on November 5, 2014, the resident was noted to be in bed with one bed rail raised nearest the window.
ii) During an interview with registered staff on November 5, 2014, it was confirmed that the resident required one bed rail to be raised when they were in bed. It was

confirmed that the resident does not attempt to exit the bed and the bed rail would not have prevented the resident from exiting the bed if they wished to. It was noted that the resident was able to hold onto the rail to assist with turning and positioning.
iii) During an interview with a personal support worker staff on November 12, 2014, it was confirmed that staff were to elevate one bed rail on the side of the bed nearest the window when the resident was in bed.
iv) During a review of the document that the home refers to as the care plan and the kardex on November 5, 2014, it was noted that the use of the bed rail when the resident was in bed was not included in the care plan. [s. 26. (3) 18.]

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' plans of care are based on, at a minimum, interdisciplinary assessment of the resident's (5) mood and behaviour patterns, including wandering, any responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, and (8) special treatments and interventions, 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. (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 outcomes of the care set out in the plan of care were documented.

The written plan of care for resident #012 directed staff to document their urinary output once per shift. Interviews with staff revealed that the urinary output was measured by the PSW and recorded each shift on the Urinary Catheter Flow Sheet. A review of the resident's Urinary Catheter Flow Sheet from October 13, to November 12, 2014 revealed that the output had not been documented 13 times. The DOC confirmed that urinary output had not been consistently documented on the Urinary Catheter Flow Sheet. [s. 6. (9) 2.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

The falls mat located at the bedside of resident #010 was observed to be unclean on November 5 and 10, 2014. Staff confirmed the falls mat was unclean. Interview with the DRC revealed falls mats should be cleaned as needed and that no schedules for the cleaning of falls mats are in place in the home. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On November 4 and November 13, 2014, the shower spa room on the Millcroft home area was observed to have black build-up between the tiles on the walls and white build-up on the tiles on floors and walls. Interview the Housekeeping Supervisor revealed that this type of build-up should be removed through the deep cleaning of the shower spa room. A review of the Daily Routine Checklist –Housekeeping Days for October 2014 revealed that the deep cleaning of shower spa room was to be completed on Fridays, however, this task had not been signed as being completed for the month. The Housekeeping Supervisor confirmed the presence of aforementioned build-up in the Millcroft shower spa room and indicated that tiles were not adequately cleaned. [s. 15. (2) (a)]

3. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A tilting shower chair in the Millcroft shower spa room was observed to have three tears in the seat covering. The Manager of Resident Care during an interview confirmed the presence of the tears in the seat cover. The Manager of Resident Care further confirmed that the tears in the seat cover posed an infection control risk to the residents using the chair. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #501 was protected from verbal abuse by a staff member at the home

i) On an identified date in 2014, during the evening meal in the dining room, three staff at the home witnessed PSW #1 making an inappropriate and disrespectful comment to resident #501 in a loud voice. Staff interviewed who witnessed the incident and witness statements confirmed that the incident took place.
ii) Resident #501 was reportedly seated at the table in the dining room with co-residents present and a verbal altercation took place between PSW #1 and resident #501. This altercation was overheard by three nursing staff members who were present.
iii) The incident was reported to the administrator immediately and PSW #1 was sent home pending investigation into the incident.
iv) PSW #1 had last received mandatory training related to prevention, reporting and elimination of abuse and neglect in May 2013.
v) The home conducted an investigation into the incident and PSW #1 received disciplinary action as a result. [s. 19. (1)]

WN #5: 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 has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The Minimum Data Set quarterly assessment dated July 2014 indicated that resident #011 had a respiratory infection in the month of July 2014. The progress notes were reviewed and did not indicate that the resident was placed on precautions for the respiratory infection. Interview with registered staff confirmed that progress notes did not indicate whether the resident was placed on precautions and confirmed that resident's name was not included in the daily infection report. There was no documented evidence that the interventions related to the respiratory infection were documented. [s. 30. (2)]

WN #6: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids are served a temperature that is both safe and palatable to the residents.

During the lunch meal service on November 13, 2014, two servings of puree banana cake were observed to sit on the servery counter for 32 minutes. The dietary aide took the temperature of the puree banana cake prior to service and revealed the temperature to be 20.8 degrees Celsius. Review of the standardized recipe for the puree banana cake revealed that staff were directed to puree the cake by adding half and half to achieve the desired consistency and to refrigerate the finished product. The home's Safe Food Handling procedure, # 10-04-03 reviewed August 2011, directs dietary staff to avoid keeping food in the Danger Zone between four and 60 degrees Celsius. Interview with the Supervisor of Nutrition Services revealed that the cake should have been refrigerated as per the recipe and was not served at an appropriate temperature. [s. 73. (1) 6.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 26. (3)	CO #002	2013_205129_0016	167
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_205129_0016	167
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_300560_0010	167

Issued on this 1st day of December, 2014

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