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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2014	2014_340566_0020	T-006-14	Resident Quality Inspection

Licensee/Titulaire de permis

BETHANY LODGE FOUNDATION
23 Second Street MARKHAM ON L3R 2C2

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

BETHANY LODGE
23 Second Street MARKHAM ON L3R 2C2

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

ARIEL JONES (566), GORDANA KRSTEVSKA (600), SARAN DANIEL-DODD (116), VALERIE PIMENTEL (557)

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 14, 17, 18, 20, 21, 24, 25, 26, 27 and 28, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), resident assessment instrument minimum data set (RAI-MDS) coordinator, environmental services manager (ESM), food service manager (FSM), life enrichment manager, physiotherapist (PT), quality assurance nurse, registered staff members, personal support workers (PSW), dietary aides, housekeeper, education coordinator, Family Council president, Residents' Council president, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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)**
- **4 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. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

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

A review of resident #003's toileting care plan, as of November 25, 2014, revealed that staff are not to leave the resident unattended while on the toilet but provide privacy. However, the care plan also stated that the call bell should be within the resident's reach and the resident should be encouraged to call the staff after toileting.
Staff interviews confirmed that the resident is not left unattended while on the toilet, and that the resident is unable to follow directions in order to use the call bell independently. [s. 6. (1) (c)]

2. Observations of resident #005 on November 21, 24, and 25, 2014, revealed that the resident used a positioning device while up in his/her wheelchair. A record review of the resident's written care plan, as of November 25, 2014, failed to identify the resident's need for the positioning device or instructions for its use.

An interview with an identified PSW confirmed that resident #005 requires the identified device to be in place at all times when the resident is up in his/her wheelchair to improve alignment and prevent contractures, and that the device is not outlined on the resident's written care plan.

An interview with the quality assurance nurse confirmed that failure to identify the positioning device on the resident's written care plan would be considered unclear directions to direct care staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the preferences of that resident.

On November 21 and 25, 2014, resident #012 was observed seated in a tilt wheelchair in his/her bedroom with the wheelchair in a slightly tilted position. A review of the resident's care plan failed to reveal evidence that the resident required a personal assistance services device (PASD) tilt wheelchair or that his/her wheelchair should be tilted as a preference.

An interview with resident #012 indicated that the resident likes to have his/her chair tilted for improved comfort and is able to ask the staff to tilt the wheelchair as needed.

An interview with an identified PSW revealed that the resident is only tilted at his/her request. Further staff interviews revealed that the resident's wheelchair should not be tilted without the PSW first notifying registered staff and an appropriate assessment initiated.

The licensee failed to consider resident #012's preference to be tilted in his/her wheelchair in the development of the resident's plan of care. [s. 6. (2)]

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

The written plan of care for resident #005 stated that the resident will be turned/repositioned every two hours while in bed, in his/her PASD tilt wheelchair, and as needed, and that a turning and repositioning flowsheet is in place for PSWs to document. A review of clinical documentation of the resident from November 2014, revealed multiple times each day when the resident was not documented as having been turned or repositioned every two hours in his/her bed or wheelchair.

Staff interviews revealed that the resident is on a turning and repositioning program, requires repositioning every two hours, and that the PSW staff are required to document on the turning and repositioning flowsheet on Point of Care (POC) when the activity is

performed, as set out in the resident's plan of care.

The written plan of care for resident #013 stated that the resident will be turned/repositioned every two hours while in his/her PASD tilt wheelchair and as needed, prompted and encouraged to reposition while in bed, and that a turning and repositioning flowsheet is in place for PSWs to document. A review of clinical documentation of the resident from November 2014, revealed multiple occasions each day when the resident was not documented as having been turned, repositioned or prompted every two hours in his/her bed or wheelchair.

Staff interviews revealed that the resident is on a turning and repositioning program related to use of a PASD tilt wheelchair, requires repositioning every two hours, and that the PSW staff are required to document on the turning and repositioning flowsheet on POC when the activity is performed or encouraged, as per the resident's plan of care.

An interview with the RAI-MDS coordinator and DOC confirmed that since residents #005 and #013 were not documented as having been turned and repositioned every two hours on the turning and repositioning flowsheet, then the care was not provided as per the plan of care. [s. 6. (7)]

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 sets out clear directions to staff and others who provide direct care to the resident, to ensure that the care set out in the plan of care is based on an assessment of the resident's preferences, and that care is provided as set out in the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by the staff.

Observations on November 14, 2014, during the initial home tour conducted by inspectors #557 and #600 revealed the following areas were unlocked and unsupervised:

Main Floor:
- door that reads "authorized personnel"

Second Floor - Harrington House:
- activity storage room (2N16)

Pringle Place:
- clean linen room (2S37)

Third Floor - Box Grove:
- housekeeping store room (3N49)
- staff bathroom
- electrical and storage room containing transformer and wires.

An interview with the ESM confirmed that the identified areas were unlocked, and the electrical room was unlocked due to a contractor accessing the area to complete required work. He/She stated locks would be installed on the activity room (gym) doors, and that he/she would ensure that all non-residential areas are kept locked to prevent resident access. [s. 9. (1) 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 all doors leading to non-residential areas are locked when they are not being supervised by the staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A record review of resident's #003's care plan revealed that the resident is frequently incontinent of bladder and wears a large-sized brief. Further review of the resident's clinical record failed to reveal the presence of a continence assessment tool that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, since the resident's admission in September 2007. [s. 51. (2) (a)]

2. A record review of resident's #008's quarterly RAI-MDS assessments from 2014 and care plan revealed that the resident is incontinent of bladder and wears pull ups. Further review of the resident's clinical record failed to reveal the presence of a continence assessment tool that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, since the resident's admission in May 2007.

A record review of resident #010's RAI-MDS assessments from the past three years and current care plan revealed that the resident is incontinent of bladder, has a history of urinary tract infections, and wears regular briefs. Further review of the resident's clinical record failed to reveal the presence of a continence assessment tool that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, since the resident's admission in May 2007.

Staff interviews revealed that the home uses the RAI-MDS assessment section H to assess a resident's continence, in combination with the PSW's continence flowsheet to determine the RAI-MDS coding during a 14 day look-back period.

A review of the home's Urinary Incontinence policy (#RCS-1-NURS-RESIDENT CARE-43, revised June 2, 2014) indicates that the nursing staff will use the assessment tools approved by the home (Urinary Continence Management Flow Chart #RCS-1-NURS-RESIDENT CARE 44b FORM). An interview with the education coordinator and RAI-MDS coordinator indicated that there was no separate continence assessment tool being used by the staff that is specifically designed for assessment of incontinence, and the RAI-MDS coordinator was unaware of the Urinary Continence Management Flow Chart.
An interview with the DOC confirmed that the home is working to create an assessment tool that is more inclusive in the assessment of residents' continence. [s. 51. (2) (a)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, 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 has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A record review indicated that six identified concerns/recommendations were directed to the dietary department during the Residents' Council meeting on June 25, 2014. Only two of the six written responses from the dietary department that were outlined on the June 2014 Food Committee meeting minutes were transferred to the Residents' Council meeting minutes for communication to the Residents' Council.

An interview with the Residents' Council assistant confirmed that he/she received the written responses to these four additional dietary concerns/recommendations but did not provide them to the Residents' Council within the designated 10 day time frame due to an oversight on his/her part. [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 a written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: 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 can be easily seen, accessed and used by residents, staff and visitors at all times.

On November 17, 2014, at 10:00a.m., the inspector observed that the call bell cord was wrapped around the side rail of the resident's bed in room #202, with the side rail in the "down" position. The call bell cord in the bathroom was observed to be wrapped around the hand bar next to the toilet and did not trigger the alarm when the inspector pulled the cord. An identified PSW and member of the registered staff assigned to the home area confirmed that the call bells were not placed in an accessible position.
The identified staff members adjusted the placement of the call bells, and confirmed that the home's policy is to ensure that call bells are within reach and placed on the top of the resident's bed when a resident is not in bed. [s. 17. (1) (a)]

WN #6: 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 skin and wound program, including interventions and the resident's responses to interventions are documented.

A record review of resident #014's care plan indicated the resident has a recurring, non-healable wound on an identified area of the body. Staff interview and further review of the wound care plan revealed the resident needs extensive assistance for bed mobility and requires turning and repositioning every two hours. A review of resident #014's turning and repositioning flowsheet for November 2014, revealed that there was no documentation that the resident has been consistently turned and repositioned every two hours. An interview with a PSW indicated that the resident was turned and repositioned every two hours, however, it was not always documented.

Interviews with registered staff confirmed that there was missing documentation on the turning and repositioning flowsheet for the turning and repositioning intervention and its effectiveness. [s. 30. (2)]

WN #7: 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 has failed to ensure that the use of a PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

Observations on November 17, 24, 25, and 27, 2014, revealed that resident #013 uses a tilt wheelchair in both a reclined and an upright position. A record review revealed that the resident has used a tilt weelchair as a PASD for positioning and comfort since an identified date in 2012. Further review of the resident's clinical record failed to reveal evidence of consent having been provided by either the resident or his/her SDM for use of the PASD tilt wheelchair.

An interview with the DOC confirmed that there was no evidence of consent having been received in resident #013's clinical record until a family care conference held on an identified date approximately three months later, when the resident's care plan was reviewed with his/her SDM. The DOC confirmed that it is the home's policy to obtain consent for use of all PASDs. [s. 33. (4) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that hazardous substances are kept inaccessible to residents at all times.

On November 14, 2014, the following observations were made:
Spa Rooms:
- products in bathroom on open shelves (including deodorants, wound cleansers, shaving cream)

Third Floor - Dickson Hill:
- kitchenette - chemicals found under the sink in an unlocked cupboard (Dustban, antimicrobial soap, Vim)
- spa room - chemicals found under the sink in an unlocked cupboard (Arjo sure wash neutralizing detergent, Arjo descaler)

Third Floor - Box Grove:
- kitchenette - chemicals found under the sink in an unlocked cupboard (Dustban, antimicrobial soap, Vim)
- dining room - chemicals found in cupboards around sink (Dustban)
- housekeeping store room (3N49) - slush sink with chemical dispenser

Second Floor - Harrington House:
- housekeeping cart - unsupervised and unlocked in the hallway, contained cleaning supplies and chemicals (Vim, 3M stainless steel cleaner).

The identified housekeeping cart and unlocked cupboards were brought to the attention of home staff and attended to immediately. An interview with the ESM confirmed that housekeeping carts should not be left unlocked and unattended in residential areas. [s. 91.]

WN #9: 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).

Findings/Faits saillants :

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

Observations conducted by inspector #116 on November 17 and 18, 2014, and by inspector #566 on November 24, 25, and 26, 2014, revealed the presence of an unclean, unlabeled bedpan and basin in the shared bathroom of rooms #314 and #315. Observations conducted by inspector #557 on November 14 and inspector #566 on November 26, 2014, revealed the presence of a shower chair in the third floor Dickson Hill shower room with a vinyl backing that was cracked, peeling and in poor repair.

An interview and tour with the Infection Control Lead confirmed that as per the home's infection prevention and control (IPAC) practices, all personal care items in shared bathrooms should be labeled to minimize the risk of cross-contamination, the vinyl backing on the shower chair that was peeling and cracked could be an infection control risk, and that all staff are expected to participate in the home's IPAC program. [s. 229. (4)]

Issued on this 11th day of December, 2014

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

Original report signed by the inspector.