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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 12, 2016	2016_356618_0019	027184-16	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

CECILIA FULTON (618), NICOLE RANGER (189)

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): September 8, 9, 12,13,14,15 and 16, 2016.

The following critical incidents were inspected: Log # 011994-16 related to an environmental incident and Log #023102-16 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Directors of Care (ADOC), Registered Dietitian(RD), Environmental Service Manager (ESM), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Physiotherapist, (PT), Resident(s), Substitute Decision Maker(s) (SDM), Residents' Council President and Family Council Representative.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration,
infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Responsive Behaviours

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

5 WN(s)
2 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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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. The licensee failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

During observations on an identified home area on September 16, 2016, the inspector noted various non drug-related items stored in the medication cart and in the double locked narcotics bin inside this cart. These items included a gold earring and an envelope with the medication cart E-pen.

Interview with RPN #109 confirmed that these items should not be stored in the double locked narcotic bin. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #2: 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 participates in the implementation of the infection prevention and control program.

On September 12, 2016, at 11:00 am on an identified home area, the inspector observed multiple residents seated in the TV lounge.

The inspector was conducting a staff interview with RPN #109 at the nursing station across from the TV lounge, when the inspector observed PSW #108 clipping resident #010 fingernails. PSW #108 then turn to the residents #011, #012 and #005 and proceeded to clip these resident's fingernails using the same nail clipper. PSW #108 did not sanitize the nail clippers between residents and did not perform any hand hygiene between residents.

The inspector stopped PSW #108 before they proceeded to another resident and inquired about the home's process for nail care. PSW #108 reported that the resident's nails are clipped on their bath days. The inspector inquired if residents have their own nail clipper and PSW #108 reported that they do. RPN #109 who had witnessed this incident confirmed to the inspector that the PSW should not be using the same nail clipper between residents, and that the nail care should be done in the shower room.

Interview with Acting Director of Care (ADOC) #111 and RPN #109 confirmed that it was the expectation of the home that all staff would participate in the implementation of the infection prevention control including not sharing nail clippers between residents. [s. 229. (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 ensure that staff participates in the implementation of the infection prevention and control program when providing nail care to residents, to be implemented voluntarily.

WN #3: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when the care as set out in the plan has not been effective.

This inspection was initiated in response a Critical Incident which was related to inappropriate touching by resident #021 of a fellow resident on July 27, 2016.

Record review revealed that resident #021 had a Cognitive Performance Scale (CPS) score of five. Resident #021 was very independent with their activities of daily living and ambulated independently throughout the unit, however they did spend a large portion of the day in their room. Resident #021 had identified behaviours of aggression and of being socially inappropriate and touching fellow residents.

Record review revealed that from December 2015 through to July 2016, resident #021 had twelve documented incidents of socially inappropriate behaviours involving touching fellow residents.

Review of resident #021's plans of care for the period of December 2015 through to July 2016 did not show any revisions to the plan of care with respect to these socially inappropriate behaviours.

Record review revealed that an assessment by a specialized resource had been scheduled for March 28, 2016. However this assessment did not occur and was never re-scheduled.

A referral to a different specialized resource was made on July 28, 2016. This was the first consult made in relation to resident #021's inappropriate social behaviours.

The plans of care remained unchanged despite the fact that it was not effective in managing the resident's behaviours. [s. 6. (11) (b)]

WN #4: 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 has failed to ensure that where they have put in place a policy that it is being complied with.

An interview with the family of resident #001 revealed that they had not been notified when there had been a discontinuation of a medication for the resident.

Review of the home's policy #RCS-1-NURS-DOC-40, Subject: Resident substitute decision maker access to information, dated January 1, 2007 reveals under procedure number four that, when a resident is reassessed and the resident's plan of care is reviewed and revised a consent or directive from the resident/POA/SDM to proceed is acquired and documented.

Record review of resident #001's Medication Administration Record (MAR), and physician progress notes revealed that on December 22, 2015, a change in medication was ordered by the physician, with a notation as to why this medication was changed.

Record review failed to reveal that there had been any communication with the family to notify them of the discontinuation of this medication.

Interview with registered staff #103 revealed that when there is a change in medication that the registered staff processing the change is expected to notify the resident's family and document that conversation in the progress notes or with a check mark on the MAR. Review of the resident record conducted by the inspector with registered staff #103 was unable to locate this required documentation.

Interview with ADOC #111 revealed that the registered staff are to notify family and document that conversation in the progress notes.

Interview with ADOC confirmed that the home's policy was not followed. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff who provide direct care to residents have received annual training in the area of behaviour management.

Interview with ADOC #110 revealed that in 2015, 40 Per cent of the home's staff did not attend the Responsive Behaviour education sessions.

Interview with ADOC #110 revealed that the home is aware of the requirements for staff to participate in this training and they acknowledged that the participation numbers for 2015 do not meet the legislative requirements. [s. 221. (2)]

Issued on this 13th day of October, 2016

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

Original report signed by the inspector.