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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2015	2015_334565_0026	032505-15	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CAREFREE LODGE
306 FINCH AVENUE EAST NORTH YORK ON M2N 4S5

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

MATTHEW CHIU (565), JANET GROUX (606), VALERIE JOHNSTON (202)

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 24, 25, 26, 27, 30, December 1 and 2, 2015.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection: 008625-14 and 022435-15.
The following Follow Up to Order Intake was inspected concurrently with this Resident Quality Inspection: 006339-15.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director of Care (DOC), Nurse Manager (NM), Supervisor of Building Services (SBS), Counsellor, Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Aides (PCA), Food Services Worker (FSW), Residents and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Safe and Secure Home

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

- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_371193_0006	202

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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of a complaint intake log indicated it was reported to the Ministry of Health and Long-Term Care (MOHLTC) that on an identified date, RN #111 performed a specified medical procedure to resident #030. After the procedure, the identified biomedical human waste was disposed of in the kitchen area.

A review of the home's policy titled "Biomedical Waste", policy #IC-0608-00, last revised on July 1, 2015, revealed biomedical human waste is limited to: bodily fluids visibly contaminated with blood; bodily fluids removed in the course of treatment/diagnosis (excluding urine or faeces) and will be disposed of in special containers (supplied by a contracted company) labelled biohazardous located in designated soiled linen room on each unit by the housekeeping department.

An interview with RN #111 indicated that he/she was unsure of the home's practice as to where to dispose of biomedical human waste and confirmed that he/she would dispose the content in a nearby sink of any resident's room or washroom that was close to the dining room.

An interview with the DOC confirmed the home's practice is for staff to dispose of biomedical human waste in the biohazardous waste containers and the above mentioned policy was not complied with. [s. 8. (1)]

2. The home's policy titled "Medication Administration", policy #PH-0201-00, review date June 1, 2015, states "document by recording the nurse's initials in space provided beside each medication; document at the time the resident receives the medication."

A review of the identified medication administration record (MAR) sheets for an identified period revealed 85 missing signatures in a month.

Interviews with RPNs #101, #118 and RN #102 indicated it is the home's expectation for registered staff to sign the MAR sheet immediately after administering a medication.

Interview with RN #102 confirmed the above mentioned MAR sheets were not signed off by registered staff as per the home's expected procedure. [s. 8. (1) (b)]

3. A review of the home's policy titled "Nursing and Personal Care Records (NCPR)", policy #NU-0211-03, last revised on July 1, 2013, revealed the following:
a) Staff will record, by initialing in the appropriate boxes, the nursing and personal care provided. The RN/RPN/PCA will indicate completion of all documentation by initialing, in the designated box at the completion of each of the shift; and
b) Complete the NCPR as follows:
- Continence-Bladder: Number of times used toilet to void-self or assisted by staff; Number of times brief or pad changed due to incontinence Pericare provided;
- Continence-Bowel: Number of times used toilet for bowel movement (BM)-self or assisted by staff; Number of times brief or pad changed due to incontinence pericare provided; and
- Bowel Movement type: indicate L=Large; S=Small; 0=no BM; N=Normal; D=Diarrhea; C=Constipation.

A review of residents #006 and #007's NCPRs for an identified four-month period revealed 38 and 106 missed entries as mentioned above respectively.

Interviews with PCAs #105, #106, RN #102 and DOC indicated it is the expectation of the home that resident care as mentioned above must be documented in the NCPRs.

Interviews with RN #102 and DOC confirmed the above mentioned policy was not complied with. [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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in acting on the satisfaction survey results.

A review of the Residents' Council meeting minutes revealed the 2014 satisfaction survey was completed and the result would be shared at the Residents' Council meeting in January 2015. Further review of the 2015 meeting minutes did not indicate the result was shared with the Residents' Council.

An interview with the Residents' Council indicated no evidence that the 2014 satisfaction survey result was shared with the Council. An interview with the Counsellor confirmed the home had completed the 2014 satisfaction survey and the home did not seek the advice of the Residents' Council in acting on the survey results. [s. 85. (3)]

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 seek the advice of the Residents' Council in acting on the satisfaction survey results, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use.

On four identified dates, the inspector observed the treatment and medication carts containing various treatment creams and medications left unlocked and unattended on two identified home areas and were accessible to anyone.

Interviews with RNs #102, #108, RPNs #101 and #102 indicated that it is the expectation of the home that the medication and treatment carts must be locked when unattended.

Interview with NM #107 confirmed the treatment and medication carts must be locked at all times when unattended by registered staff and they were not. [s. 130. 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 ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

A review of a complaint intake log in 2015 revealed that an anonymous complaint was reported to the MOHLTC, and it was related to staffing shortage resulting in resident care not being provided such as bathing and incontinence care.

A review of the home's staffing plan indicated the home did not have a written back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act, cannot come to work.

An interview with the DOC confirmed that the home does not have a written staffing plan as mentioned above. [s. 31. (2)]

WN #5: 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 review of Residents' Council meeting minutes revealed that on an identified date, a concern was raised regarding the meal service rotation on the first floor dining room. The home used a Residents' Council Follow Up form to respond to the Council, and a written response was provided on this form 13 days after.

An interview with the Residents' Council indicated no recollection of the date that the Council received the above mentioned written response. An interview with the Counsellor confirmed he/she gave the written response to the Council 19 days after receiving the Council's concern. [s. 57. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
- The date the drug is ordered;
- The signature of the person placing the order;
- The date the drug is received in the home; and
- The signature of the person acknowledging receipt of the drug on behalf of the home.

Record review of the identified drug record book in a two-month period revealed a total of 113 entries missing the date the drug is ordered and/or received, and the signature of the person placing and/or receiving the order.

Interviews with RN #102, RPNs #114 and #118 revealed that the home's practice is the registered staff ordering and/or receiving must document the date of when the drug is ordered and/or received, and the signature of the person placing and/or receiving the order.

An interview with RN #102 indicated that the home's expectation is the date and signature of the registered staff ordering and/or receiving must be documented and confirmed this was not done. [s. 133.]

Issued on this 4th day of February, 2016

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

Original report signed by the inspector.