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
Jan 31, 2017	2016_334565_0019	034177-16	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), KAREN MILLIGAN (650), 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): December 13, 14, 15, 16, 19, 20, 21, 22, and 23, 2016.

During the course of the inspection, the following intakes were inspected:
- Critical Incident Intake #009472-14 related to resident fall with injury,
- Complaint Intake #009139-14 related to improper care of a resident, and
- Follow-up to Order Intake #004049-16 related to individualized menu for residents.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care, Nurse Manager, Registered Dietitian, Food and Nutrition Services Manager, Counsellor, Resident Assessment Instrument – Minimum Data Set Coordinator, Registered Nurses, Registered Practical Nurses, Personal Care Aides, Physiotherapist, 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, record review of resident and home records, meeting minutes for Residents' Council, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
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
Skin and Wound Care

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

4 WN(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2015_321501_0014	565
O.Reg 79/10 s. 71. (5)	CO #001	2015_321501_0014	565

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. 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 had been documented.

During stage one of the Resident Quality Inspection (RQI), staff interview revealed resident #003 had a specified altered skin integrity and resident #009 had a worsening of a specified altered skin integrity identified in the most recent Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment.

A review of the home's Skin and Wound Program Policy, RC-0518-02, published 01-04-2016, directs staff to "follow repositioning/turning schedule for those residents who are dependent on staff for repositioning as per plan of care repositioning resident every two hours".

A review of the clinical records for resident #003 and #009 revealed the following:

- Resident #003's plan of care revealed that the resident required a specified assistance to turn side to side, reposition and move from lying position in bed. The written plan of care directs staff to change the resident's position every two hours both while in bed or wheelchair. Resident #003 had been identified with a specified altered skin integrity on an identified date, and had deteriorated three months later.

- Resident #009's plan of care revealed that the resident required a specified assistance for repositioning. The written plan of care directs staff reposition the resident every two hours and to complete the repositioning and turning sheet. The records indicated that on an identified date, a specialist assessed the resident's specified altered skin integrity and recommended that staff change the resident's position at least every two hours.

Interviews with Registered Practical Nurse (RPN) #102 and Personal Care Aide (PCA) #103 indicated that resident #003 and #009 are turned and repositioned every two hours. The staff further indicated that when a resident is repositioned, the time and position of the resident is documented on the turning/positioning schedule worksheet.

A review of the home's turning/positioning schedule worksheets permits staff to document every two hours from 0800 hours until 0600 daily. The turning/positioning schedule worksheets for both resident #003 and #009 for an identified four-month period revealed that staff had documented sporadically and on the random days where staff had documented, there was no documentation on any day for an identified 14-hour period.

Interviews with both the Director of Care (DOC) and RPN #102 indicated that although staff would have turned and repositioned both resident #003 and #009 every two hours as required, staff had only documented the resident's response to the turning and repositioning intervention on random days and had not documented at all for the identified 14-hour period on any day. [s. 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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI, staff interview revealed resident #003 had a specified altered skin integrity and resident #009 had a worsening of a specified altered skin integrity identified in the most recent RAI-MDS assessment.

A review of the home's Skin and Wound Program Policy, RC-0518-02, published 01-04-2016, directs registered staff to assess identified resident wounds weekly and to complete the skin and wound assessment sheet.

A review of the clinical records for resident #003 and #009 revealed the following:

- Resident #003 had been identified with a specified altered skin integrity on an identified date, and had deteriorated three months later.
- Resident #009 had an ongoing specified altered skin integrity and on an identified date, the resident's altered skin integrity had been assessed as a specified stage.

A review of the weekly skin and wound assessments for resident #003 and #009 for an identified four-month period indicated that resident #003's altered skin integrity had not been assessed by a registered staff member using a clinically appropriate assessment tool for skin and wound assessment on two identified dates, and resident #009's altered skin integrity had not been assessed on an identified date, as required. [s. 50. (2) (b) (iv)]

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 received 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 circumstance of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

During stage one of the RQI, the most recent RAI-MDS assessment indicated resident #008 was incontinent.

A review of the home's Management of Bowel Function Policy, RC-0520-04, published 01-04-2016, and Urinary Continence Management Policy, RC-0520-00, published 01-04-2016, indicated the home uses a Continence Assessment tool for identifying causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Resident #008 was admitted to the home on an identified date. A review of the RAI-MDS assessments indicated the resident had been incontinent since admission. Further record review revealed the admission Continence Assessment was not completed for the resident, and he/she did not receive any other Continence Assessment since admission.

Interview with PCA #117 indicated resident #008 was incontinent and a toileting schedule was implemented for the resident. Interview with Registered Nurse (RN) #116 and the DOC confirmed that the resident did not received a continence assessment as required. [s. 51. (2) (a)]

2. During stage one of the RQI, the RAI-MDS assessment indicated resident #004 was incontinent.

Resident #004 was admitted to the home on an identified date. A review of the admission Continence Assessment revealed the resident was continent. A review of the RAI-MDS assessments revealed the resident's continence status had changed from continent to incontinent over an identified 15-month period. Further review of the assessment records indicated the resident did not receive a continence assessment when he/she became incontinent.

Interview with RPN #115 indicated the resident had been incontinent for over two years and his/her continence status had declined. Interview with RN #116 indicated the resident did not receive a continence assessment when he/she became incontinent.

Interview with the DOC indicated when the resident's continence status had changed to incontinent, staff should initiate an assessment using the home's Continence Assessment tool. The DOC confirmed that resident #004 did not receive a continence assessment as required. [s. 51. (2) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the initial tour of the RQI on December 13, 2016, the inspector observed that the home posts the copies of the inspection reports on the information board in the main floor hallway near the front entrance. The inspection report #2015_334565_0026 from the past two years was not posted by the home.

Subsequent observations on December 16 and 19, 2016, and interview with the Acting Administrator confirmed that the above mentioned report was not posted as required. [s. 79. (1)]

Issued on this 7th day of February, 2017

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

Original report signed by the inspector.