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
Mar 27, 2015	2015_262523_0004	L-001969-15	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE VI LIMITED PARTNERSHIP
458 Glencairn Avenue TORONTO ON M5N 1V7

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

CHELSEY PARK (OXFORD) NURSING HOME
310 OXFORD STREET WEST LONDON ON N6H 4N6

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

ALI NASSER (523), DONNA TIERNEY (569), SALLY ASHBY (520)

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): March 2, 3, 4, 5, 9, 10, 11, 12 & 13, 2015

The following Critical Incidents and Complaint inspections were conducted concurrently during this inspection:
Log # 002662-15 / CI 2655-000009-15
Log # 003617-15 / CI 2655-000017-15
Log # 002155-15 / CI 2655-000007-15
Log # 002836-15 / IL 37333-LO

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Environmental Services Manager (ESM), Education Manager, Registered Dietitian, two Dietary Aides, two Housekeeping Staff, a Maintenance Staff, a Laundry Services Staff, seven Personal Support Workers, 11 Registered Staff, Resident Council Representative, Family Council Representative, three family members and 40 residents.
The inspector(s) also toured the home, observed meal service, medication pass, medication storage areas and care provided to residents, reviewed health records and plans of care for identified residents, reviewed policies and procedures of the home and observed general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **9 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

A review of a resident's clinical record revealed that the resident had a change in condition and the staff did not notify the physician in a timely manner.

This was confirmed by the Director or Resident Care.

2. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

a) A review of a critical incident report revealed that a staff member on 2 consecutive days was discussing with the resident a personal matter in the dinning room in front of other residents. Resident asked the staff member several time not to do so.

This was confirmed by the Director of Resident Care, who also confirmed that it is the home's expectation that resident's right for privacy be respected.

b) An observation during the RQI revealed that while staff were positioning a resident the privacy curtains and door open were open and resident's body was exposed and visible to passers in the hallway.

This was confirmed by a Registered Staff member, who also confirmed that the home's expectation is that the resident right to be afforded privacy in care is respected and promoted. [s. 3. (1) 8.]

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 resident's right to be properly cared for in a manner consistent with his or her needs and to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs were fully respected and promoted, 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. (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 care set out in the plan of care is provided to the resident as specified in the plan.

A review of a resident's clinical record revealed that the resident's weekly treatment was not provided for 2 weeks.

This was confirmed with the Director of Resident Care who also confirmed that it is the home's expectations that the care set out in the plan of care be provided to the residents. [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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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) Observations during RQI revealed that the home did not comply with their Policy titled "The Medication Pass" by placing medications on top of the medication cart.

B) Observations during RQI revealed that the home did not comply with their Policy titled "Drug Destruction and Disposal" by not completing all required documentation.

The Director of Resident Care verified that the home's expectation is that all the home's policies and procedures be complied with. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.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 stairways must be kept closed and locked.

Observation during the RQI revealed that a door leading to a stairway was unlocked. This door is not located in a resident care area but may be accessible by residents.

This was confirmed by the Administrator and Director of Resident Care who also confirmed the expectation is that this door which leads to the stairway needed to be kept closed and locked at all times. [s. 9. (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 all doors leading to stairways must be
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During resident observations it was noted that 3 beds with bed rails up had a mattress that would slide from side to side. This was confirmed by a Maintenance Staff.

A review of the bed assessment done by the home revealed that those beds were identified as failed in certain zones of entrapment but did not indicate what was done to mitigate the risk.

The Maintenance Manager and the Administrator verified the bed assessment was not accurate and needed to be re-done and that it did not accurately reflect what changes had been made and when to mitigate risk to the resident taking into consideration all potential zones of entrapment.

The Administrator confirmed in an interview that the home's expectation is that where bed rails are used steps will be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (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 where bed rails are used steps will be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #6: 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 has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observations during the RQI revealed some wall damage to some common areas.
Chairs in common areas had extensive damage and are in need of repair.
A bathroom used by residents and staff had extensive ceiling damage (patched, but not painted) and damaged flooring.

Multiple residents' rooms on all floors noted to have damage to walls, door frames and ceilings.

The Maintenance Manager verified the above maintenance concerns and stated that the home's expectation is that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that Abuse of a resident by the staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

A review of the internal investigation report revealed that staff who witnessed an alleged incident of abuse did not report the incident.

The Director of Resident Care initiated an internal investigation report but did not report the Critical Incident to the ministry until 13 days later.

An interview with the Director of Resident Care confirmed that the staff did not report the incident immediately; and that the CI was not reported immediately to the ministry.

The Director of Resident Care confirmed that it is the home's expectations that incidents like this be reported immediately. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that neglect of a resident by the staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

A review of a critical incident report revealed that the residents had not received their afternoon snacks or supplements.
This was reported 4 days after its occurrence.

Interview with the Director of Resident Care confirmed that the staff who first became aware of the incident did not report it to the home until 4 days after the incident occurred and that it is the home's expectation that any staff who has knowledge of improper or incompetent treatment or care of residents should report that immediately. [s. 24. (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 the person who had reasonable grounds to suspect that Abuse of a resident by the staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: 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 ensure that advice is sought of the Family and Residents' Councils in developing and carrying out the home's annual satisfaction survey.

During the RQI it was noted that the home did not seek the advice of the Resident and Family Councils in developing and carrying out the home's annual satisfaction surveys.

This was confirmed with the Director of Resident Care, who also confirmed that the home's expectation is to seek the advice of the family and resident's council in developing and carrying out the satisfaction survey. [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 ensure that the home will seek the advice of the Resident's and Family Councils in developing and carrying out the satisfaction surveys, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record is kept up to date at all times.

A clinical record review for 5 residents revealed that the care plans in point click care were not signed off to reflect the completion of the review and to keep record up to date.

This was confirmed by the Director of Resident Care and the Administrator, who both confirmed that it is the home's expectation that care plans be signed off once updated or completed and every record should be kept up to date. [s. 231. (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 the resident's written record is kept up to date at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Observations during the RQI revealed that a resident's medication was on the shelf with the resident's name blackened out and the RX number mostly removed.

The Director of Resident Care could not explain why this had happened and confirmed that the home's expectation that medication packaging should never be mutilated or blackened out. [s. 126.]

Issued on this 27th day of March, 2015

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

Original report signed by the inspector.