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
Nov 2, 2016	2016_382596_0011	023231-16	Resident Quality Inspection

Licensee/Titulaire de permis

SLOVENIAN LINDEN FOUNDATION
52 NEILSON DRIVE ETOBICOKE ON M9C 1V7

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

DOM LIPA
52 NEILSON DRIVE ETOBICOKE ON M9C 1V7

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

THERESA BERDOE-YOUNG (596), GORDANA KRSTEVSKA (600)

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): August 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2016.

The following Critical Incident (CI) intakes were inspected concurrently with this RQI: 019650-15, 021871-16, 005288-16, 021710-16, 022760-16 and 004578-16.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), education coordinator (EC), facilities coordinator (FC), activation coordinator (AC), resident assessment instrument (RAI) coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), activation aides (AA), housekeepers, dietary aides, Residents' Council members, residents and family.

During the course of the inspections, the inspectors toured the home, observed resident care, observed staff to resident interactions, reviewed resident health records, internal investigation notes, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

5 WN(s)
1 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. (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 was provided to the resident as specified in the plan.

Record review of a Critical Incident (CI) report submitted to the Ministry of Health and Long Term Care (MOHLTC) in February 2016, reported that an identified resident sustained a fall in his/her washroom on a specified date in February 2016. The resident sustained an injury and complained of pain; subsequently the resident was transferred to hospital for further assessment.The identified resident returned from hospital two days later with diagnoses of two medical conditions.

Record review of the identified resident's written plan of care at the time of the incident, directed staff to ensure that resident wears hip protector at all times while awake, due to risk of falls.

Interview with an identified personal support worker (PSW) revealed that he/she discovered that the identified resident had fallen in the washroom on a specified date in February 2016, while doing rounds. The identified PSW reported the identified resident wandered a lot on the night shift, was at risk for falls and admitted being aware that the resident's written plan of care indicated the use of hip protectors while awake. The identified PSW stated that he/she saw the resident wandering near the nursing station fifteen minutes prior to the fall, and admitted that he/she did not ensure that the resident was wearing the hip protector when he/she sustained a fall on a specified date in February 2016.

On a specified date in August 2016, the inspector observed the identified resident sitting in a TV lounge with other residents; it was noted that the resident was not wearing a hip protector under his/her clothing.

Interview with a second identified PSW revealed he/she was aware that the resident's written plan of care indicated the use of a hip protector due to risk of falls. The second identified PSW stated that it was the responsibility of the day shift staff to put on the resident's hip protector in the morning, and that he/she did not check if the resident was wearing the hip protector at the start of his/her evening shift due to being busy providing care to other residents.

Interview with a third identified PSW who provided care for the resident on a specified date in August 2016 on the day shift, reported that he/she was aware that the identified resident's plan of care included the use of a hip protector, and forgot to put it on the resident on the above mentioned date in August 2016. [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 was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of a CI report submitted to the MOHLTC in February 2016, revealed that on a specified date in February 2016, an identified housekeeper reported to the Executive Director (ED) that another identified housekeeper had shown him/her several photos on a cellphone, of two identified residents which had been taken without the residents' awareness.
Interview with the first identified housekeeper confirmed that the second identified housekeeper had shown him/her several photos from his/her cellphone of the two identified residents, and photos of other residents' rooms and toilets. The first identified housekeeper further stated he/she was aware about the home's expectation that staff were not to carry personal cellphones while working in the resident home areas (RHA).

Review of the home's policy titled Telephone, Communication and Cell Phone Use, #HR 6.08.ON, issued August 1, 2011, revealed personal communication system, including cellphones, for personal matters while on duty are prohibited except in emergencies. The policy review also revealed that staff are prohibited from making illegal transactions, threats, harassing telephone calls or taking photographic images, sending text messages or anything else which contravenes the employee conduct policy while using telephone system, cellphones or other wireless communication devices. Violation of this policy will be considered a serious offense and will be subject to disciplinary action up to and including termination of employment.

Review of the home's investigation notes indicated that the second identified housekeeper had used his/her cellphone to take photos of residents' rooms and toilets that had not been cleaned.

Interview with the facilities coordinator (FC) confirmed the second identified housekeeper had approached him/her on a couple of occasions showing photos on his/her cellphone of residents' rooms and bathrooms. The FC disciplined the housekeeper for not following the home's policy for using communication devices; the staff had also been provided with re-education regarding the above mentioned policy. The second identified housekeeper continued to use his/her cellphone when he/she took photos of the two above mentioned residents.

Interview with the DOC confirmed the second identified housekeeper had not complied with the home's above mentioned policy despite the warnings and additional education he/she had been provided. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of a CI report submitted to the MOHLTC in February 2016, reported that an identified resident sustained a fall in his/her washroom on a specified date in February 2016. The resident was transferred to hospital for further assessment.

Record review of the resident's clinical record with the DOC, revealed that a post-falls assessment was not completed using the home's post fall assessment instrument. Interview with an identified RN reported that he/she did not document the resident's fall on a specified date in February 2016, using the clinically appropriate assessment instrument specifically designed for falls, that is used in the home.

Interview with the DOC revealed that registered staff are expected to document all resident falls on the home's post fall assessment instrument, using the electronic documentation system. The above mentioned RN did not complete a post fall assessment for the identified resident's fall in February 2016. [s. 49. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining annually relating to the following:
-The Residents' Bill of Rights
-the home's policy to promote zero tolerance of abuse and neglect of residents
-the duty to make mandatory reports under section 24
-the whistle-blowing protections.

Record review of the home's staff training records for 2015 and interview with the ED and education coordinator revealed the following:
19 out of 61 staff had not received retraining regarding Resident Bill of Rights, 15 out of 67 staff had not received retraining regarding residents' abuse and neglect and promoting zero tolerance of abuse, 10 out of 54 staff had not received retraining regarding mandatory reporting and 11 out of 54 had not received retraining regarding whistle blowing protections. [s. 76. (4)]

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. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

Record review of the home's staff training records on Falls Prevention and management revealed that 14 out of 49 staff did not receive training in 2015.

Interview with the Executive Director confirmed that 14 out of 49 staff did not receive falls prevention and management training in 2015. [s. 221. (1) 1.]

Issued on this 4th day of November, 2016

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

Original report signed by the inspector.