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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Sep 28, 2016	2016_363659_0027	027431-16	Resident Quality Inspection

Licensee/Titulaire de permis

EDEN HOUSE CARE FACILITY INC
R.R. #2 GUELPH ON N1H 6H8

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

EDEN HOUSE NURSING HOME
5016 Wellington County Road 29 R. R. #2 GUELPH ON N1H 6H8

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

JANETM EVANS (659), ANN POGUE (636), MARIAN MACDONALD (137)

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 13, 14, 15, 16, 19, 20 and 21, 2016.

The following follow up and intakes were completed within this Resident Quality Inspection: 005704-16 Follow up to CO # 001 Inspection 2016-253614-0001 related to ensuring that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents. Critical Incident # 005890-16 - 2777- 000001-16 related to staff to resident abuse and neglect and Critical Incident Log # 001326-14 - 2777-000019-14 related to a resident fall with injuries sustained.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration and storage areas, and required Ministry of Health and Long-Term Care postings.

During the course of the inspection, the inspector(s) spoke with the Owner/Best Practice Nurse, the Administrator, the Director of Care, the Nutritional Manager, the Dietitian, Acting Activation Manager/PSW, Maintenance, Housekeeping, the Resident Assessment Instrument (RAI) Coordinator and RAI Coordinator back up, Registered Nurses, Registered Practical Nurses, Maintenance staff, Laundry staff, Personal Support Workers, the Resident Council President; Family Council Representative and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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. 17. (1)	CO #001	2016_253614_0001	137

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. 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 were maintained in a safe condition and in a good state of repair.

Observations, during Stage 1 of the Resident Quality Inspection revealed loose and wobbly grab bars attached to the toilet in the washroom, between two identified rooms on H wing.

The grab bars were not secure, could be moved away from the toilet and posed a potential fall risk to the residents who used the grab bars.

The Director of Care (DOC) # 102 was informed and acknowledged the loose grab bars posed a potential fall risk to residents.

On September 14, 2016 at 0815 hours, the Director of Care (DOC) # 102 said any grab bars, not needed, were removed. However, the grab bars in the washroom, between two identified rooms on H wing, were needed.

DOC # 102 said that maintenance was not able to tighten these grab bars as this was their design and was going to check to see if there were any other type of grab bars available in storage, to replace the existing ones.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level two - minimal harm or potential for actual harm and compliance history was a level 2, no related non-compliance. [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 related to ensuring that the home, furnishings and equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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 a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident had been immediately reported to the Director.

On October 22, 2015, the Director of Care (DOC) #102 was notified of an incident which alleged that Personal Support Worker (PSW) # 119 had been rough in the provision of care to resident #001. PSW #119 was sent home on October 22, 2016 and the home's investigation into the incident was initiated on October 22, 2016.

A review of the Critical Incident System on September 15, 2016 by Inspector #137 did not show that a critical incident (CI) had been submitted by this home for this incident.

During an interview with DOC #102 on September 16, 2016, she said that she had initially investigated the incident as possible abuse. The DOC #102 acknowledged that she had not notified the Director of the alleged abuse.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level two - minimal harm or potential for actual harm and compliance history was a level 1, no previous non-compliance. [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 related to ensuring that a person who has reasonable grounds to suspect that abuse of a resident by anyone that results in harm or risk of harm to the resident will be immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

On September 19, 2016, during an interview with the Registered Dietitian (RD) #120 she stated that she used to come to the home every week and spent an average of 17-20 hours per month on site. The frequency of the on site visits had recently been changed from weekly to biweekly.

A review of the resident list from Point Click Care for the approximate census for June and July 2016 showed that there were 51 residents in the home, requiring 25.5 on site RD hours and for August 2016 there were 54 residents in the home, requiring 27 on site RD hours.

A review of the dietitian's invoicing for June, July and August 2016 showed that the RD had consulted on site for 20.5 hours in June; 18.5 hours in July and 15.5 hours in August 2016.

The RD was not on site at the home for a minimum of 30 minutes per resident per month in June, July or August 2016 to carry out clinical and nutrition care duties.

The scope of this area of non-compliance was determined to be a level two - pattern, the severity was a level two - minimal harm or potential for actual harm and compliance history was a level 1, no prior non-compliance. [s. 74. (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 with respect to ensuring that the dietitian would be on site for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to bed rail use set out clear directions to staff and others who provided direct care to the resident.

Resident #004 was assessed on May 1, 2015 for bed rails by Personal Support Worker (PSW) #105. At that time it was recommended that the resident did not require bed rails.

Resident #004 was observed September 13, 16 and 19, 2016 with a half rail and transfer rail in a raised position. From interviews with PSW's # 104, 120 and RPN #111 on September 16 and 19, 2016, Inspector #659 was told that the resident liked the rails to be in a raised position to assist with bed mobility and that staff raised the bed rails for this resident.

During an interview with resident #004 on September 19, 2016, she verbalized her preference to have the bed rails in a raised position as she was afraid of falling out of bed and that she sometimes used the bed rails to assist with bed mobility.

On September 16, 2016, a review of the plan of care dated August 3, 2016, did not identify the use of bed rails for this resident.

The licensee failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to the resident with respect to bed rail use.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level one - minimal harm and compliance history was a level 2, no related non-compliance. [s. 6. (1) (c)]

WN #5: 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 they complied with their policy of Hydration: Section 11 Feeding and Hydration; Subsection 11.1 Feeding and Hydration, revised June 2015, which documented that residents who did not meet their fluid needs for three consecutive days would be placed on a fluid watch: the Registered staff would activate a fluid watch task in Point of Care (POC) to alert nursing staff to the need to increase fluids; a dietary referral was to be sent to the Food Services Manager(FSM)/Registered Dietitian (RD) to communicate that the fluid watch had been started and the FSM/RD was to update the care plan; Registered staff must assess the resident for signs and symptoms of dehydration and document the results of that assessment; all staff were responsible to document all fluid intake in POC. Once the resident had met their fluid needs for seven consecutive days the Registered staff would discontinue the fluid watch in POC and notify the FSM/RD. Any of all dietary interventions would be reassessed by the RD.

The plan of care was reviewed and resident 004's targeted fluid intake was documented by the dietitian in the resident's plan of care.

In an interview with the dietitian on September 19, 2016 she stated that there was a benchmark for fluid intake and if a resident had three consecutive days of fluid intake less than 75% of the benchmark, then a fluid watch should be initiated

Resident #004's fluid intake was recorded on Point of Care (POC) and it was identified that it was less than 75% of the targeted goal for fluid intake over a three day period.

Review of the progress notes, Medication Administration Record and Treatment Administration Record for resident #004 did not show evidence that the resident was

placed on a fluid watch or that a referral was made to the dietitian.

Registered Nurse (RN) #122 confirmed that a referral had not been made to the dietitian and that the resident #004 had not been placed on a fluid watch in May 2016 when her fluid intake had decreased to less then 75% of her targeted goal.

The Licensee failed to comply with their policy of Feeding and Hydration related to initiation of a fluid watch and a dietitian referral.

The scope of this area of non-compliance was determined to be a level two - pattern, the severity was a level two - minimal harm or potential for actual harm and compliance history was a level 3, prior related non-compliance. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, related to infection prevention and control practices.

Resident #110 had a surgical intervention which required the use of a special appliance.

A review of the policy related to cleaning the identified appliance provided specific procedures for staff.

On September 13, 2016 at 1210 hours, Inspectors # 137 and # 165 observed a used, unclean appliance stored in a shared washroom for an identified room on H wing.

On September 14, 2016 at 0840 hours, Inspector # 137 observed a used, unclean appliance stored in a shared washroom for an identified room on H wing.

On September 15, 2016 at 0920 hours, Inspector # 137 observed a used, unclean appliance stored in a shared washroom for an identified room in H wing.

Interviews, on September 15, 2016 at 1312 hours, Personal Support Workers (PSW) # 104 and # 108 said they were not familiar with the policy and did not follow the instructions to clean the appliance as identified in the policy.

Interviews, on September 15, 2016 at 1400, Registered Nurse (RN) # 110 and Registered Practical Nurse (RPN) # 111 said the appliance was changed weekly and described the cleaning process. RPN # 111 identified the cleaning mixture and said the

cleaning mixture was likely stored in the resident's bedside table.

RN # 110 and Inspector # 137 toured the room of resident # 010. With the resident's permission, RN # 110 checked the bedside table and washroom. There was no evidence of the cleaning mixture. Two used, unclean appliances were observed on the bottom shelf of the bedside table, creating a foul odour. One appliance was dated July 28, 2016 and the other appliance was not labelled. RN # 110 and RPN # 111 said the appliances had not been cleaned or disposed of, as per the home's policy.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level two - minimal harm or potential for actual harm and compliance history was a level 2, no related non-compliance. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Observations, on September 13, 2016 at 1210 hours, September 14, 2016 at 0930 hours and 1330 hours, September 15, 2016 at 0920 hours and 1140 hours and September 16, 2016 at 1035 hours, revealed a strong odour present in the washroom, for identified rooms on H wing.

Personal Support Worker (PSW) # 108, Maintenance Worker # 116, Housekeepers # 109 and # 117 acknowledged the strong odour present. PSW # 108 said the odour was a long-standing issue and had been present for at least six weeks.

Inspector # 137 asked Director of Care (DOC) # 102 for a copy of the home's policy for addressing incidents of lingering offensive odours. Policies were provided related to cleaning resident rooms, bathrooms, and wet mopping. None of the policies included addressing incidents of lingering offensive odours.
The DOC # 102 said if an odour was identified, it was dealt with.

Maintenance Worker # 116 acknowledged that there was no procedure developed and implemented for addressing incidents of lingering offensive odours.

The scope of this area of non-compliance was determined to be a level one – isolated, the severity was a level one – minimal harm and there was no history of related non-compliance. [s. 87. (2) (d)]

Issued on this 30th day of September, 2016

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

Original report signed by the inspector.