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

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Performance Improvement and Compliance Branch

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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 2, 2015	2015_353589_0011	T-1660-15	Resident Quality Inspection

Licensee/Titulaire de permis

ESTONIAN RELIEF COMMITTEE IN CANADA
40 OLD KINGSTON ROAD SCARBOROUGH ON M1E 3J5

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

EHATARE NURSING HOME
40 OLD KINGSTON ROAD SCARBOROUGH ON M1E 3J5

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

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), TILDA HUI (512)

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): May 19, 20, 21, 22, 25, 26, 28 and 29, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, director of care (DOC), dietary manager, registered dietitian (RD), program manager, physiotherapist (PT), administrative assistant (AA), maintenance manager, registered nursing staff, personal support worker(s)(PSWs), minimum data set-resident assessment instrument (MDS-RAI) coordinator, dietary aides (DA), cooks, residents, substitute decision makers (SDM's), toronto public health nurse(TPH), President's of Residents Council and Family Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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

11 WN(s)
3 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 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.

Review of the home's policy titled Hydration Management, section 4.9 indicated that the registered nursing staff are required to make a referral to interdisciplinary team members, and the RD is required to reassess resident's nutritional and hydration status including weights on a quarterly or monthly basis as per risk assessment.

Record review of the most recent minimum data set (MDS) assessment indicated that residents #001, #002, and #010 had specified health conditions March 2015. Health assessments completed thereafter revealed the above mentioned residents were assessed for sign and symptoms of the specified health conditions.

Interview with registered nursing staff #102 confirmed that referrals were not completed and forwarded to the RD or physician for the above identified residents. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of the home's policy titled Medication Disposal, policy number 5.8, revision date October 2010, stated that "medication designated for disposal are to be stored safely and securely within the home, separate from drugs that are available for administration to a resident, in a designated area until the destruction and disposal occurs. In most cases, medications designated for disposal are comprised of expired drugs, drugs with illegible labels, drugs in containers that do not meet the necessary marking requirements as outlined in the DPRA, drugs that were held or refused, discontinued drugs, drugs for a deceased resident, or drugs for a discharged resident that were not sent with the resident".

On May 29, 2015, the inspector observed one bottle of an identified medication that had expired April 2015, in the government stock room shelf.

Interview with registered nursing staff #102 and the DOC confirmed that expired medications are not to be kept in the storage room among drugs that are available for administration to a resident, and are to be put in the disposal bin in the medication room for destruction. [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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home complete a nutritional assessment for the resident whenever there was a significant change in the resident's health condition and assess the resident's hydration status, and any risks related to hydration.

Record review of MDS assessment on an identified date in February 2015, revealed that resident #001 had experienced an altered hydration status. Record review of the progress notes revealed that from an identified period between February to May, 2015, resident #001 had been assessed by registered nursing staff for signs and symptoms of an altered hydration status.

Interview with registered nursing staff #102 indicated the resident had not been assessed by the RD. Interview with the RD confirmed that he/she did not assess resident #001's hydration status or any risks related to hydration since the registered nursing staff's initial documentation on an identified date in February, 2015, related to signs of an altered

hydration status.

Record review of MDS assessment dated on an identified date in March, 2015, revealed that resident #002 had an altered hydration status. Record review of the progress notes revealed that from an identified period between March to May, 2015, resident #002 had been assessed by registered nursing staff for signs and symptoms of an altered hydration status.

Review of the RD's quarterly assessment on an identified day in March, 2015, revealed that resident #002 experienced a weight change over an identified period related to altered health conditions; the resident's average daily fluid intake was reported to be less than the resident's daily fluid requirement.

Interview with the RD confirmed that he/she did not assess resident #002's hydration status or any risks related to hydration since the registered nursing staff's initial documentation on an identified date in March, 2015, related to signs of an altered hydration status.

Record review of MDS assessment on an identified date in March, 2015, revealed that resident #010 had experienced an altered hydration status. Record review of the progress notes revealed that from identified dates in February to May, 2015, resident #010 had been assessed by registered nursing staff for signs and symptoms of an altered hydration status. Record review of the resident's most recent written plan of care revealed that the physician had ordered an identified fluid restriction related to an altered lab work result for resident #010.

Interview with the RD confirmed that he/she did not assess resident #010's hydration status or any risks related to hydration since the registered nursing staff initial documentation on an identified date in February, 2015, related to signs of an altered hydration status. [s. 26. (4) (a),s. 26. (4) (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 registered dietitian who is a member of the staff of the home complete a nutritional assessment for the resident whenever there was a significant change in the resident's health condition and assess the resident's hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the Toronto Public Health (TPH) recommendations for Tuberculosis (TB) Screening in Long Term Care (LTC) and Retirement Homes updated on February 14, 2013 revealed that Tuberculin skin tests (TST) are not recommended to be done upon admission for residents 65 years of age or older. A review of the Canadian TB Standards, 6th edition (CTS 2007) advises that residents 65 years of age and older of LTC Institutions undergo baseline posterior-anterior and lateral chest X-rays.

Health record review of resident immunization records for the following three residents revealed they had received TB screening using the 2-step TST:
-resident #021 (over 65 years old), admitted on an identified date in March, 2015,
-resident #022 (over 65 years old), admitted on an identified date in March, 2015,
-resident #023 (over 65 years old), admitted on an identified date in April, 2015,

Interview with the DOC and an identified TPH nurse confirmed that the home's Infection Prevention and Control Program is not in accordance with evidence-based or prevailing practices related to their TB screening program. [s. 229. (2) (d)]

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 Infection Prevention and Control program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Record review of the written plan of care dated March 6, 2015, revealed that resident #001 has some of his/her dentition. One staff is required to provide total assistance for the resident's oral care daily, two times per day.

Interview with PSWs # 107 and #106 indicated that resident #001 is no longer capable of spitting out the tooth paste from his/her mouth and does not always open mouth therefore; staffs are using a swab with mouth wash to provide oral hygiene.

Interview with registered nursing staff #102 confirmed resident #001's oral care includes, brushing teeth and if the resident refuses, staff are to use a swab with mouth wash. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out is no longer necessary.

Record review of the most recent written plan of care indicated that resident #003 had

incontinence. The written plan of care identified incontinence with goal to be clean, dry, odor free and to wear an incontinent brief.

Interview with PSW #107 confirmed that resident #003 wears an incontinent brief however is continent.

Interview with the quality and MDS-RAI coordinator confirmed that resident #003 is continent and that the written plan of care had not been reviewed and revised since the change in the resident's status from incontinent to continent.

On May 29, 2015, the quality and MDS-RAI coordinator revised resident #003's written plan of care to reflect resident #003's status as continent.

Interview with registered nursing staff #104 revealed that on admission in August 2014 resident #009 ambulated independently with an assistive aid. On an identified date in December, 2014, an incident resulted in resident #009 being hospitalized for a identified period in December, 2014. Resident #009 sustained an injury which resulted in a significant change in his/her mobility status and now required extensive assistance by one staff member for transfers and used an alternative assistive aid for mobility.

Record review of the most recent written plan of care for therapy and nursing indicates resident #009 transfers independently and uses an assistive aid for mobility.

Interview with registered nursing staff #104 confirmed that the most recent written plan of care had not been reviewed and revised to identify resident #009's change in health status and mobility needs. [s. 6. (10) (b)]

WN #5: 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

On May 19, 2015 at 10:40 a.m., the inspector observed the soiled utility room door closed but not locked. The lock pad on the door was observed to be not functional. There were two electrical panels and two open wired boxes inside the room. There was no staff present in or in the vicinity of the room.

Interview with registered nursing staff #117 indicated that the malfunctioning lock was documented in the maintenance log book on May 13, 2015, and had not been fixed. Interview with the maintenance staff confirmed the lock was stuck and needed oiling. A follow-up observation on the same day revealed the lock was functional. [s. 9. (1) 2.]

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

On May 19 and 21, 2015, the inspector observed holes in the dining room walls below the window and behind the door and that five ceiling tiles were not resting securely on the support bars with potential to fall down.

Interview with dietary aide (DA) #118 indicated that the ceiling tiles had been in this state for the past two to three months. Interview with the ESM confirmed the above observations. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On May 19, 2015, the inspector observed that the hair salon did not have a resident-staff communication and response system in place. The hair salon is located on the basement level of the home and is shared by residents from the Retirement Home (RH)and the Long Term Care (LTC).

Interviews with registered nursing staff #105 and the DOC confirmed that the hair salon is open for all residents of the RH and LTC home. At the time of the inspection, there was one LTC resident who visited the hair salon weekly.

The DOC confirmed that there is no call bell installed in the hair salon. [s. 17. (1) (e)]

WN #8: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home.

Record review of progress notes revealed that on identified date in May, 2015, a medical procedure was completed on an identified area of resident #005's body. Physician's orders on the same day directed the staff to wash the identified area with soap and water for two weeks and to apply a medicated ointment twice daily until healed.

Interview with registered staff #104 revealed a referral to the RD was not completed. Interview with the RD confirmed an assessment of the altered skin integrity was not completed.

Health record review of the electronic treatment administration record (e-TAR) indicated daily dressing changes to altered skin integrity to an identified area on resident #012's body had been in place since an identified date in January, 2015. Record review of resident #012's progress notes and most recent written plan of care revealed that a RD referral was not completed.

Interview registered nursing staff #104 revealed that a referral to the RD was not

completed related to resident #12's altered skin integrity.

Interview with the RD confirmed that an assessment of resident #012's altered skin integrity was not completed. [s. 50. (2) (b) (iii)]

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

Record review of the e-TAR's for January, February, March, April and May 2015 for resident #012 indicated weekly skin assessments are to be completed every Tuesday as ordered by the physician on January 28, 2015.

Interviews with registered nursing staff #101 revealed and confirmed that on two identified dates in April, 2015, weekly skin assessments were not completed for resident #012. [s. 50. (2) (b) (iv)]

WN #9: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bladder continence based on the assessment.

Record review of the MDS assessment dated March 22, 2015, revealed that resident #002 is frequently incontinent and requires the use of incontinence products. Record review of the resident's most recent written plan of care indicates that he/she usually requires extensive assistance with toileting, especially in the evening.

Interview with PSW #107 and registered nursing staff #106 indicated that the resident transfers him/herself to the toilet, and then calls for assistance after toileting.

Registered nursing staff #106 confirmed that resident #002 does not have a scheduled toileting routine that promotes and manages continence. [s. 51. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids in the food production system are stored, using methods to preserve taste, nutritive value, appearance and food quality.

On May 9, 2015, at 12:30 p.m., the inspector observed a container of an identified protein supplement stored in the bottom drawer of the medication cart on the LTC floor. The container did not indicate the date it was opened. The manufacturer guidelines indicated to: "discard three months after opening".

Interview with registered nursing staff #102 confirmed he/she was not aware that the identified protein supplement required labeling with the date it was opened. The staff then disposed of the container in the medication discard bin designated for destruction. [s. 72. (3) (a)]

WN #11: 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 including 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.

Review of the home's drug record book noted the following medications not signed off and not dated by the registered nursing staff when received from pharmacy:
1. an identified medication ordered on an identified date in March, 2015 for resident #003
2. an identified medication ordered on an identified date in March, 2015 for resident #009
3. an identified medication ordered on an identified date in March, 2015 for resident #013

Interview with registered nursing staff #102 and the DOC confirmed that it is the expectation of the home for medications received from pharmacy to be signed off and dated by registered nursing staff. [s. 133.]

Issued on this 14th day of September, 2015

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

Original report signed by the inspector.