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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 12, 2015	2014_157210_0022	T-025-14	Resident Quality Inspection

Licensee/Titulaire de permis

ELM GROVE LIVING CENTRE INC
35 ELM GROVE AVENUE TORONTO ON M6K 2J2

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

ELM GROVE LIVING CENTRE INC.
35 ELM GROVE AVENUE TORONTO ON M6K 2J2

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

SLAVICA VUCKO (210), ARIEL JONES (566), SARAH KENNEDY (605)

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 18, 22, 23, 24, 29, 30, 31, 2014 and January 1, 2015

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), activation therapists, director of care(DOC), administrator, program manager (PM), physiotherapist (PT), residents, families

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 plan of care sets out clear directions to staff and others who provide direct care to the resident.

Interview with identified activation staff indicated that resident #5 receives one to one recreation activities such as reading short stories and music therapy when the music therapist visits the home not following any particular schedule. Review of the clinical record indicated that in the month of November 2014 the resident received music therapy five times in total and private visit/bedside activity a total of four times. The activation therapist was not able to provide other evidence that the resident received any kind of music therapy and bedside activity before or after November 2014, until the moment of the inspection.

Review of the written plan of care indicated the resident has partial involvement in activation programs due to lack of interest/ chronic pain and fatigue, psychiatric disorder, depressive episodes and unspecified fracture. The goals were to identify at least two activities that the resident would like to participate in; the resident to be encouraged and

reminded about daily programs to increase socialization with staff; and the resident to be invited to programs when he/she is in the mood and respect and support any refusals for participation. The following interventions were described in the written plan of care: 1:1 contacts to be arranged with the resident; any refusals for participation to be documented; the resident to be given opportunity to express opinion of activities attended; to offer activity program directed toward specific interests/ needs of the resident; to provide weekly activity schedule and explain the events; to respect resident's choice in regard to limited/ no activities; and to visit once per day with the resident to develop or sustain contact using conversation.

Interview with the resident confirmed that he/she likes listening to music if he/she is not in pain. He/she used to read but not any more and he/she would enjoy if someone reads to him/her especially in his/her native language.

Review of the clinical record and interview with identified activation staff confirmed that the written plan of care did not give clear direction about the resident's preferences for activities. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Interview with resident #5 indicated the resident spends most of the time in bed because he/she has body pain and if he/she is up in wheelchair he/she would be in discomfort. He/she usually spends most of the time in bed, receives meals in bed and is not involved in any common programs/activities. The registered nursing staff asked the resident in front of the inspector if he/she would like to take the PRN (as needed) pain medication (Tylenol 650mg PRN) and the resident confirmed.

Interview with identified registered nursing staff and physiotherapist (PT) indicated that resident #5 has constant pain at certain parts of the body. The PT indicated that the resident is not on physiotherapy since November 25, 2013, because most of the times he/she refused the therapy. The PT further confirmed that the resident was known to everybody to be in constant pain in certain parts of the body. Interview with an identified PSW indicated that when he/she assisted the resident with the morning care he/she was making grimaces as he/she was in pain, and he/she did not report it to the registered nursing staff. Interview with the registered nursing staff confirmed that he/she was not informed that the resident was in pain. Review of the clinical record and further interview

with the registered nursing staff confirmed the given PRN medication was not the most effective, the resident still complained of pain, and that he/she would inform the doctor. During the four-month period of September, October, November and December, 2014, until the moment of the inspection, the PRN pain medication was given on three occasions, on September 14, 18, and 20, 2014.

Review of the resident's written plan of care contained the section for pain that stated the resident had pain related to occasional complaints of back pain, he/she was not on scheduled pain management medications, and staff to administer PRN (as needed) medication to be pain free. The interventions described were: staff to ask the resident at regular intervals if he/she has pain; administer PRN pain medications as per MD orders and note the effec; acknowledge presence of pain and discomfort, listen to resident's concerns, document/report complaints & non-verbal signs of pain.

Interview with DOC confirmed that when ever he/she would meet with resident #5 he/she would mention that he/she had problems with his/her back, and that he/she used to be on regular pain medications, but he/she was not aware if he/she was on any pain medications now.

Review of clinical record and interview with registered nursing staff, PSW and PT confirmed staff did not collaborate with each other in the assessment of the resident's pain. [s. 6. (4) (a)]

3. Interview with an identified PSW indicated resident #11 refused to have his/her teeth brushed in the morning using a toothbrush. Interview with a registered nursing staff indicated that the expectation is the PSWs to communicate with registered nursing staff when the care is refused in order further to assess the resident.

Interview with an identified registered nursing staff confirmed that it was not communicated to registered staff when the resident refused the care in order to implement different approaches and update the care plan. [s. 6. (4) (a)]

4. a)Interviews with 4 different identified PSWs indicated that resident #6 frequently refuses to have his/her shower. Review of the PSWs' documentation indicated the resident received two showers in September 2014, one shower in October, 2014, and refused all showers in November and December, 2014.

Interview with registered nursing staff indicated the expectation was any refusal of care,

such as showers, is to be reported to registered nursing staff in order to identify why the resident is refusing care, document in progress notes and update the plan of care.

Interviews with two registered nursing staff confirmed that the resident's refusal of showers was not communicated to registered nursing staff.

b)Interviews with PSWs revealed that resident #6 refuses showers and the only strategy they implement is to re-approach the resident. Interview with an identified registered nursing staff revealed that resident #6's family is very involved with his/her care and they can be called to encourage the resident to accept his/her bathing care.

Review of the written plan of care of resident #6 indicated this strategy is not documented as a successful intervention for giving showers.

Interview with two identified PSWs confirmed they were not aware of the strategy to call the family when trying to offer showers to the resident.

c)Interview with an identified PSW revealed that resident #6 refuses showers most of the times or almost all of the times because the resident complains of shortness of breath (SOB).

Interview with a registered nursing staff indicated that the resident has a history of complaining of SOB and that it has not been reported to nursing staff for several months that the resident complained of SOB when the shower was offered and refused. The registered nursing staff further indicated that it could be that the resident pretended that he/she has SOB in order to refuse shower, but the expectation is any refusal of care such as shower, or resident's complaint of change in health status be reported to registered nursing staff in order to assess the resident.

Interview with a PSW indicated that it was a known behavior of the resident to complain of SOB when shower was offered in order to avoid it and this was not always reported to registered nursing staff.

Review of the written plan of care indicated that registered nursing staff should monitor the effectiveness of inhalation puffers /medications and monitor and document respiration, color, cough and sputum when the resident complains of SOB. The written plan of care did not indicate that the resident would complain of SOB just to refuse the shower.

Staff involved in the different aspects of care did not collaborate with each other in the assessment of the resident's refusal of care, involvement of the family in the resident care and complaints of SOB. [s. 6. (4) (a)]

5. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

1. On December 30, 2014, it was observed that a male PSW was providing care to resident #11. Interview with the male PSW indicated that the resident refused some of the personal care.

Review of the resident's written plan of care indicates that male staff should not provide care as per the resident's wish.

An interview with an identified PSW indicated that the expectation is that a female PSW should always be providing care to this resident. The same PSW stated that if a male staff member is assigned to resident #11 then the PSWs should be reassigned to make sure that resident #11 receives care from a female staff member.

Interview with a registered nursing staff confirmed that the care of resident #11 was not provided as per the written plan of care.

2. Interview with resident #11 and identified PSW indicated on December 30, 2014, that his/her teeth were not cleaned in the morning using a toothbrush.

Review of resident #11's written plan of care indicated that he/she is able to brush teeth with set-up help and repetitive cueing.

Interview with identified PSW working on December 30, 2014, confirmed that resident #11's teeth were cleaned using mouthwash only. There is no indication in the care plan that resident #11 should be using mouthwash only.

An interview with a registered nursing staff indicated that the expectation is the care plan is always followed.

Interview with registered nursing staff and a PSW confirmed the care was not provided to the resident as per the written plan of care. [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 plan of care sets out clear directions to staff and others who provide direct care to the resident, staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the care set out in the plan of care is 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. 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:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in pain management, including recognition of specific and non-specific signs of pain.

Review of the training records for pain management in 2014 indicated 0% of PSWs and 63% of registered nursing staff were not provided training in pain management including recognition of specific and non-specific signs of pain.

Review of the training records and interview with DOC confirmed that not all direct care staff were trained in pain management. [s. 221. (1) 4.]

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 direct care staff are provided training in pain management, including recognition of specific and non-specific signs of pain, 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 policy Medication Management is complied with. O. Reg. 79/10, s. 8 (1).

Review of the Medication Management policy, reviewed on July 2014, states eye drops must be discarded after 28 days of original date of opening, unless directed otherwise by the pharmacy or manufacturer. Registered staff must date the bottle when it is opened and date when it is to be discarded.
Review of the current guidelines for determining /monitoring expiry dates of medications that the home is using in Remedy's Rx which are posted in medication rooms, indicates if insulin is open at room temperature it should be used for one month from the date opened.

During an observation of the medication card on 1st floor on December 31, 2014, at 9:30 a.m., a bottle of eye drops of "Visine" and insulin Humulin R Penf was found to be opened for use but there was no date to indicate when they were opened.

Interview with registered nursing staff confirmed that the eye drops and the insulin did not indicate the date when the medication was opened and they should be labeled every time when opened for staff to know until when the medications were good to use. [s. 8. (1) (b)]

WN #4: 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 equipment is kept clean and sanitary.

Observation performed on December 18, 2014, at 2:48 p.m. indicated that resident #9’s walker was covered in crumbs.
Observation performed on December 22, 2014, at 1:51 p.m. indicated that resident #1’s walker was dirty and covered in crumbs and other debris.
Observation performed on December 23, 2014, at 11:50 a.m. indicated that resident #8’s wheelchair had many white stains on the seat cushion and foot supports.

Interview with a registered nursing staff indicated that the expectation is that residents' equipment is to be cleaned on a weekly basis by the night-shift staff according to a cleaning schedule or if the equipment is found to be soiled to be cleaned immediately.

Review of the cleaning schedule documentation indicated the equipment was cleaned on December 23, 24 and 26, 2014.

Interview with a PSW and observation on December 29, 2014, confirmed that residents #1, 8 and 9’s equipment was soiled and was not kept clean and sanitary. [s. 15. (2) (a)]

WN #5: 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: the date the drug is received in the home and the signature of the person acknowledging receipt.

Review of the shipping report printed on December 18, 2014, indicated medications were received in the home by a particular registered nurse but there was no date when the medications were received. The registered nursing staff provided the shipping record for December 2014, but was not able to provide the shipping records for the other months of the last two years.

Review of the clinical record and interview with identified registered nursing staff confirmed that when medications are shipped by pharmacy, the shipping report is not dated when the medications are received in the home.

Interview with DOC confirmed that the shipping records for medications are not kept in the home for two years and revealed only shipping records for November and December, which were not dated and signed by the registered staff who received the medications. [s. 133.]

Issued on this 20th day of January, 2015

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

Original report signed by the inspector.