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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2015	2015_440210_0005	T-1662-15	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), SARAH KENNEDY (605), SUSAN LUI (178)

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): June 23, 24, 26, July 2, 3, 6, 7, 8, 9 and 10, 2015.

The following complaint intake inspection was completed during this inspection: T-2217-15, and critical incident system report: T-1167-12, T-1448-14, T-394-14 and T-825-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Programs Director, Office Coordinator, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI MDS Coordinator, Activation Staff, Food Services Supervisor (FSS), family members and residents.

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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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 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 secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with locks to restrict unsupervised access to those areas by residents.

Observation on June 23, 2015, at 9:45a.m., revealed that the door leading out onto a secure outside terrace from the 3rd floor solarium was unlocked. Inspector #605 entered the outdoor terrace and was unable to re-enter the home because the door was locked from the outside. If a resident wandered out through the unlocked door, this could potentially trap a resident in the secure outdoor area. It was observed that there was also a locked fire door leading from the 3rd floor outdoor terrace out onto the street.

Inspector #605 pulled the call bell to alert staff. Interview with staff member #125 confirmed that the inspector was locked on the terrace.

Interview with registered staff member #110 revealed that the door does not lock from the inside; however, if the door is opened an alarm should go off. The same staff member confirmed that the alarm did not go off when inspector #605 opened the terrace door because the alarm system was not turned back on after the terrace was last used. Staff member #110 confirmed that every time the terrace is used by a resident, the alarm system is turned off. The expectation is for the alarm system to be turned back on.

During an interview with the Administrator, it was confirmed that the door leading out to the 3rd floor terrace is unable to lock from the inside. Therefore, the door remains unlocked at all times. The Administrator stated that the door remains unlocked at all times because the door leads to a fire door. It was confirmed that the door leading to a secure outside area that precludes exit by a resident, including balconies and terraces, was not equipped with a lock to restrict unsupervised access to those areas by residents.

Prior to exiting the home, the Administrator stated that a mag lock door had been ordered to replace the door that does not lock from the inside. [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 secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with locks to restrict unsupervised access to those areas by residents, 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).

Review of Critical Incident Report #2515-000021-14 indicated that home staff received a report from a family member of alleged staff to resident abuse in 2014, but the allegation was not reported to the Director under the LTCHA until three days later.

Interviews with staff #108 and with the home's Director of Care (DOC) confirmed that an identified resident's family member reported the abuse allegation to the home's staff in 2014, but the allegation was not reported to the Director under the LTCHA until three days later. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily menus are communicated to residents.

Observation on June 23, 2015, at 12:00p.m., revealed that the daily menu was not posted anywhere near the 3rd floor dining room.

Interview with registered staff member #110 confirmed that the daily menu was not posted, however the weekly menu was posted. The same staff member mentioned that the daily menu is only posted outside the ground floor dining room.

Interview with the Food Services Supervisor confirmed that the daily menu was not posted. The same staff member stated that the expectation is for the daily menu to be posted so that it is communicated to residents who attend meal service in the 3rd floor dining room. [s. 73. (1) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies.

Observation on July 9, 2015, at 10:30 a.m.,on 2nd floor unit, revealed that the narcotic box located in the medication cart contained money and narcotic medications. Interview with registered nursing staff #121 indicated the money belonged to a resident and the narcotic box is where the money is safe and easily accessible when the resident needs it. Interview with the DOC revealed that the resident's often become upset when they do not have easy access to the money.

Observation and interview with registered staff confirmed that the narcotic box was not used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

WN #5: 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 program is evaluated and updated at least annually in accordance with evidence-based practices.

The home's policy titled "Infection Prevention and Control, Tuberculosis Screening and Mantoux testing", revised July 2014, indicated that "residents will have a two step Tuberculosis Screening Test (TST) either before or within 14 days of admission to Elm Grove Living Centre unless it is medically contraindicated".

Review of the communication letters to long term care homes revealed on April 18, 2013, Public Health Toronto sent a letter to administrators of long term care homes in regards to updated recommendations for tuberculosis (TB) screening in long term care facilities. The letter states: Toronto Public Health recommends that TB screening for all new residents be based on a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. It is recommended that this assessment include the following:
• A symptom review for active pulmonary TB disease.
• A chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility.
• If signs and symptoms and/or chest x-ray indicate potential active pulmonary TB disease, the resident should not be admitted until three sputum samples taken at least eight hours apart are submitted to the Public Health Lab for testing (Acid Fast Bacilli and Culture) and the results are negative. (It can take up to 8 weeks for a culture report).
In addition to the above, for residents < 65 years of age who are previously skin test negative or unknown, a 2-step tuberculin skin test (TST) is recommended. If the TST is positive, treatment of latent TB infection (LTBI) should be considered. A TST is not recommended for residents with a previous positive TST.
Tuberculin skin tests are not recommended to be done routinely upon admission for residents 65 years of age or older. If a TST was previously done, record the date and result of the most recent TST.

The policy is not in compliance with evidence based practice as identified in Canadian Tuberculosis Standards, seventh edition, 2013, such as all new residents be assessed on the bases of a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission, according to recommendations as stated above. [s. 229. (2) (d)]

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Issued on this 21st day of August, 2015

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

Original report signed by the inspector.