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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2014	2013_215123_0017	H-001930-12,H-000105-13	Complaint

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 30, 31, August 21, 22, 23, 27, 28, 29,30, September 18, 2013

Concurrent inspection #2013_215123_0017

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Program Manager, program staff, Registered Staff, Personal Support Workers, Laundry Staff, Dietary Staff, Staffing Coordinator, Cleaning Staff, Family Council members, residents and family members.

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed resident's records, observed resident care, observed staff-resident interactions, inspected supplies and equipment and observed medication administration.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Family Council

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 of the home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.
During the review of resident #0010 record numerous documentation was found indicating that medications were being administered by Health Care Aides (HCA). The progress note documentation in other residents' records were reviewed and contained documentation of HCA administering medications. Medication administration was observed on different shifts, on different days and on all home areas. Medications were observed being administered by registered staff only. The Director of Care was interviewed and reports that HCA/ Personal Support Workers do not administer medications in the home. The staff are not following the home's policies and procedures related to the documentation of medication administration. The DOC has contacted the vendor and they are unable to remove it. Staff will be re-instructed. [s. 8. (1)]

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 failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
During the inspection the inspector identified four incidents of alleged abuse of four residents (residents #002, #008, #009, #0010) by the home's staff that the home was aware of but that the home did not report to the Director. The home's records were reviewed including the Concerns Record, and the home's investigation records and documentation indicates that the home was aware of the allegations. The residents' records were reviewed. The staff involved in all incidents were interviewed. Residents were interviewed where possible. The Director of Care (DOC) was interviewed and confirmed the home's awareness of the allegations, and the validity of the information in the home's records. The DOC confirmed that the home did not notify the Director as required. Inspector requested that the home notify the Director as required. [s. 24. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.
The home's records including the Family Council Meeting Minutes and Action Logs. The Family Council Acting Chair, Family Council Acting Secretary and the Program Manager were interviewed. The Administrator reported that she meets with the Family Council and answers their concerns or questions. Some of the responses that the Administrator reported were provided to the Family Council in response to the Family Council's concerns and questions including the responses related to the outdoor space, the changes in the flooring were not documented in the Family Council Minutes or the Action Logs. [s. 60. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. On August 28, 2013 a full storage bin of clothing with the words Items to be Labeled written on it was observed in a third floor Hazel Lane utility room. Blank clothing labels and regular iron also observed in the room. Inspector over-heard the registered staff informing the family members of a newly admitted resident that labels will take one week to a week and a half to be printed and delivered to the home. The Administrator, Director of Care (DOC) and Staffing Clerk were interviewed and reported that the home does not have a labeling machine for residents clothing. The labels are not printed in the home. They are ordered from and printed by an outside service provider. The labels can take up to a week and a half to arrive. There are blank clothing labels and an iron available on the home area. A staff person is scheduled on the home area to apply the labels to the residents clothes for twenty minutes on Mondays. DOC reports that new residents usually have hand-written labels applied to one set of clothes and the family takes the rest of the resident's clothing home to launder until the labels arrive. The residents' clothing are not labeled in a dignified manner within 48 hours of admission. [s. 89. (1) (a) (ii)]

2. On August 22, 2013 Hazel Lane face cloth supply was inspected. There were no face cloths observed on any of the Personal Support Worker (PSW) care carts. Storage area on the unit was checked and no face cloths were found. PSW were interviewed and reported that they get the supply in the mornings and afternoons. Sometimes they run out and need more. Six to eight of the face cloths come up. Each PSW usually gets six to eight face cloths. The home's laundry was checked and there were nine face cloths on one linen cart and five on one linen cart. Inspector counted twenty-eight face cloths in the laundry storage area with the laundry staff member. The laundry staff member was interviewed and reported that: The staff on the units throw the face cloths into the garbage. Sometimes the laundry staff finds the face cloths in the garbage. The home has just purchased a large quantity of face cloths and they were put in circulation and sent to the units. They are thrown out by the staff. Green and blue linen carts located outside the Assistant Director of Care (ADOC) office area across from the laundry was inspected and there were no face cloths on the carts. The Administrator was interviewed and reported that fifteen dozen face cloths were just purchased by the home. The Administrator has the purchasing record. Each shift one hundred to two hundred face cloths are sent to each floor. Twelve dozen face cloths were put into circulation last week. The staff throws them out sometimes. The home did use disposable facecloths in the past. A sufficient supply of face cloths are not always available in the home for use by residents. [s. 89. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
Two identified residents #001 and #0010 were observed by the home's staff to have injuries of unknown origin. The residents' records were reviewed including the care plans and progress notes. The home's investigation records including Concern Form were reviewed. The Director of Care (DOC) was interviewed and reports that investigations into the cause of the injuries were completed and the cause of the residents' injuries could not be determined. The home did not notify the residents' Power of Attorneys (POA) within 12 hours of becoming aware of the injuries. [s. 97. (1) (b)]

Issued on this 26th day of February, 2014

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