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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Mar 22, 2017	2017_552531_0006	002724-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF FRONTENAC
2069 Battersea Road Glenburnie ON K0H 1S0

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

FAIRMOUNT HOME FOR THE AGED
2069 Battersea Road R. R. #1 Glenburnie ON K0H 1S0

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

SUSAN DONNAN (531), CRISTINA MONTOYA (461), PATRICIA MATA (571)

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): February 13, 14, 15, 16 and 17, 2017

The following inspections were conducted concurrent with this inspection:
Log # 031032-16 related to falls prevention
Log # 001739-16 related to low lighting levels
Log # 034181-16 related to alleged neglect
Log # 029443-16 related to alleged staff to resident emotional abuse
Log # 003870-17 related to alleged staff to resident verbal abuse
Log #003868-17 related to alleged staff to resident emotional abuse

During the course of the inspection, the inspector(s) spoke with residents', residents' Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Registered Dietitian (RD), a Dietary Aide (DA), a Activation Assistant (AA)t, the Environmental Services Manager (ESM), the Director of Care (DOC) and the Administrator.
The inspectors reviewed residents health care records, observed residents' care and services, observed residents' dining services, measured illumination levels, reviewed the Resident Council meeting minutes , observed medication administration and reviewed appropriate policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
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.

4 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. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that required levels of lighting were provided in all areas of the long term care home including: a minimum of 215.28 lux of continuous, consistent lighting throughout corridors, residents' rooms, en-suite washrooms and common area washrooms.

On February 15 and 16, 2017, illumination levels in the corridors, in residents' rooms, residents' en-suite washrooms and common area washrooms were measured by inspector #531. A hand held Amprobe LM-120 was used. The meter was held 3 to 4 feet above the floor surface and all available window covers and doors closed. All available light fixtures were turned on and warmed up.

During the RQI in 2016, the inspectors noted low lighting levels in corridors and residents en-suite washrooms. During the RQI in 2016, resident #021, complained that the lighting in the washroom was not bright enough. The resident also indicated he/she had difficulty grooming as the light was positioned in such a way it illuminated from behind.

During this inspection, resident #015 complained to inspector #531 that the lighting in the en-suite washroom was dark. Resident #015 indicated that the maintenance worker replaced the bulb upon request that morning, however it did not improve the illumination level.
Resident #031 told inspector #531 that the lighting in his/her en suite washroom was dim. Resident #031 indicated that he/she has compromised sight and the light is dark at night.
A minimum level of 215.28 lux of continuous, consistent lighting was not provided in corridors throughout the home. Levels of illumination in corridors were measured at 50 to 75 % of the required lighting levels including resident seating areas along the corridors of each home unit.

Levels of illumination in a sample of 40 resident en-suite washrooms measured 50% of the required lighting levels of 215.28 lux.
Levels of illumination in the resident common washroom adjoining e. 205 family lounge measured 50% of the required lighting levels of 215.28 lux.

On February 15, 2017 the Environmental Services Manager (ESM), equipped with a light meter, accompanied inspector #531 and measured sample of residents' en-suite washrooms and the 2 North corridors.
The ESM acknowledged the low illumination levels in residents' en-suite washrooms and corridors. He indicated that a light fixture had been identified as appropriate to provide the required levels of illumination in washrooms, the first had been installed this week. He indicated that the illumination levels in corridors and the residents' en-suite washrooms will be measured and replaced to provide the required lux level of 215.28.

Insufficient lighting levels may negatively impact the ability of staff to clean effectively and to deliver safe and effective care to the residents. Low levels of illumination and shadows may negatively impact residents' perception of the surrounding environment affecting mobility and overall quality of life. [s. 18.]

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 required levels of lighting are provided in all areas of the long term care home; including a minimum of 215.28 lux of continuous, consistent lighting throughout corridors, residents' en-suite washrooms and common washrooms, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD is used to assist resident with a routine activity of daily living only if the use of the PASD is included in the resident's plan of care.

On February 15 and 16, 201, during supper meal services, inspector #461 observed that resident #009 was sitting on a Feeder Chair with a lap tray applied.

On February 15, 2017, at the lunch meal time, the resident was observed sitting on his/her wheelchair set up on a regular dining table for the meal. At supper time on the same day, inspector #461 observed that resident #009 was sitting on the Feeder Chair with the lap tray applied trying to reach out for a drink that was placed on the left hand side of the lap tray. When the resident could not see the glass of juice, the resident stated how do I get out of here referring to the lap tray. A PSW proceeded to put the drink on the right side of the lap tray, and resident did not ask to get out of the chair or lap tray again. Resident #009 began to eat the meal independently. A PSW and RN were close by provided cueing, and cutting up food.

A review of resident #009's progress notes from the past three months, indicated that the resident had specified behaviours, but no indication for the need of a Feeder Chair during meals were found in the records. Review of theresident's most updated plan of care showed no interventions related to the use of a PASD in the form of a lap tray applied to a feeder chair during meal times.

On February 15, 2017, at the supper meal time, and on February 16, 2017, at lunch meal time, inspector #461 observed resident #026 in the dining room sitting on a Broda Feeder Chair with a lap tray applied. The meals and beverages were served on the lap tray, and staff provided assistance with the meal.

A review or resident #026's notes from the past three months, indicated that resident had specified behaviours, but no indication for the need of a Feeder Chair during meals were found in the records. Review of resident's most updated plan reviewed on February 16, 2017, showed no interventions related to the use of a PASD in the form of a lap tray applied to a feeder chair during meal times.

Inspector #461 observed resident #027 on February 15, 2017, at the lunch meal time, and on February 16, 2017, at the supper meal time sitting on a Broda Feeder Chair with a lap tray applied for meals.

A review of resident #027's progress notes from the past three months, indicated that the resident had specified behaviours, but no indication for the need of a Feeder Chair was found. Review of resident's care plan as of February 16, 2017, showed no interventions related to the use of a PASD in the form of a lap tray applied to a feeder chair during meal times.

On February 15, 2017, in an interview with RPN #107, Inspector #461 asked RPN #107

how the staff decided which residents required the feeder chair. RPN #107 indicated that there were no assigned seats for residents in the evening on the One-North Unit where residents #009, #026, and #027 were located due to their behaviours. The Broda Feeder chairs were used for those residents that needed feeding assistance and extra cuing with meals, and decisions were made at each meal. RPN #107 indicated the need for the feeding chair and lap tray was not always put in the resident's chart because it was not considered a restraint.

On February 15, 2017, in an interview with PSW #108. PSW #108 indicated that the Feeder Chairs with the lap trays were only used at breakfast, lunch, and supper, because the lap tray were considered a restraint and could not be left on for a long time. The PSW indicated there were always staff close to the residents to assist them. PSW #108 indicated that as far as she knew, the use of feeder chairs were not in the care plan as the RPN and staff determined at each meal which resident required to be seated in one of those chairs. The PSW indicated the need of the feeding chair is judged by resident's alertness, it could be different residents at different meals.

On February 16, 2017, in an interview with RN #109, the RN indicated the feeding chairs and lap trays were used only for an hour during meals while assisting residents with eating. It was not considered a restraint, that's why it was not always placed in the care plan because the residents changed from day to day. RN #109 indicated that if it was a restraint they needed to have an order and everything in place. Inspector asked RN #109 how was the consent obtained from resident's family, and RN #109 indicated the nurses usually reviewed the need for the feeder chair with family and obtained a verbal consent from them. RN #109 indicated there was not a form filled out for residents when needing a feeder chair. Inspector asked the RN if she would consider the lap tray a PASD, RN #109 reported that it was in fact a PASD because it helped to assist residents during meals only, but it was perhaps not considered as a PASD, because the staff were always in the dining room monitoring. RN #109 further reported that if at some point, someone needed to use the chair, the nurses allowed the staff to use them. It was not always the same residents. RN #109 added that whenever the feeder chairs were needed, this was discussed at some point with the families, on admission or when needed. The families were advised on admission, that over the One-North unit residents didn't have assigned seats, it depended on the day.

RN #109 further indicated that resident #009 was now in a wheelchair, and did not require the Feeder Chair as he/she was not displaying specified behaviour as much. However, resident #009 was placed in the feeder chair when less alert. As for resident

#026, RN #109 indicated resident #026 always sat in the feeder chair for meals because the resident always displayed a specified behaviour. As for resident #027, RN #109 indicated that the resident was not consistent with using the feeder chair. For instance, the RN reported that the morning of February 16, 2017, resident #027 did not require a feeder chair.

On February 16, 2017, in an interview with the DOC indicated that PASDs were devices used to assist residents with their daily living activities. The DOC indicated it was expected that the staff monitored, documented, and obtained consent from the SDM. Inspector #461 also inquired about For m #38 that was mentioned in the PASD policy. The DOC indicated that the Form #38 outlined what device were being used, who in the interdisciplinary team was involved, if there were other PASDs, other alternatives that had been considered, and if the SDM had been consulted. DOC indicated that currently the ADOC and RPN #110 were in charge of the RAI documentation and reviewing the residents' care plan related to PASDs.

On February 16, 2017 in an interview with RPN #110. The RPN provided a copy of the Form #38 "Referral for Restraint and/or PASD" - 200-05-02 Appendix II. RPN #110 indicated that this form was used only on admission, but it was not kept in the chart when it needed to be archived. The home's expectation is that the need for the feeding chairs should be reviewed quarterly under the ADL RAP assessments.

On February 17, 2017, inspector #461 spoke with the DOC. The DOC indicated that she had reviewed with the staff of the One-North Unit the care plans for residents #009, #026, and #027 and the care plans were updated related to the PASD in the form of feeder chairs with lap trays applied during meal times. The DOC indicated that she had spoken with the RN and RPN of the One North Unit and advised them about following the home's PASD policy. The DOC acknowledged there were gaps in the implementation of the PASD policy, and even the residents who did not use the feeder chair with lap tray very often this should still be noted in the care plan as needed. The DOC also acknowledged that staff should be obtaining a consent from the residents' POA for the use of any PASD. DOC indicated that more education was needed for the staff.

After observations, review of health records, and interviews with the staff; it was determined that the plan of care for residents #009, #026, and #027 did not include the use of a PASD in the form of Feeder Chairs with lap trays to assist residents during meal times. [s. 33. (3)]

2. The licensee has failed to ensure that the use of the PASD had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

On February 15 and 16, 2017, during supper meal services, inspector #461 observed that resident #009 was sitting on a feeder chair with a lap tray applied.

On February 15, 2017, inspector #461 observed that resident #009 was sitting on the feeder chair with the lap tray applied trying to reach out for a drink that was placed on the left hand side of the lap tray. When the resident could not see the glass of juice, stated how do I get out of here referring to the lap tray. A PSW proceeded to place the drink on the right side of the lap tray, the resident did not ask to get out of the chair or lap tray again. Residen #009 began to eat the meal independently. A PSW and RN were close by provided cueing, and cutting up food.

A review of resident #009's progress notes from the past three months, indicated that resident #009 had specified behaviours, but no indication for the need of a feeder chair during meals were noted. A consent for the use of a PASD from resident's SDM was not located in the records. Review of resident's most updated plan of care, showed no interventions related to the use of a PASD in the form of a lap tray applied to a feeder chair during meal times.

On February 15, 2017, at the supper meal time, and on February 16, 2017, at the lunch meal time, Inspector #461 observed resident #026 in the dining room sitting on a Broda Feeder Chair with a lap tray applied. The resident's meals and beverages were served on the lap tray, and staff were providing assistance with the meal.

A review of resident #026's progress notes from the past three months, indicated that the resident had specified behaviours, but no indication for the need of a Feeder Chair during meals were noted. A consent obtained for the use of a PASD from resident's SDM was not located in the records. Review of the resident's most updated plan of care showed no interventions related to the use of a PASD in the form of a lap tray applied to a feeder chair during meal times.

Inspector #461 observed resident #027 at the supper meal time on February 15, 2017 and at the lunch meal on February 16, 2017, sitting on a Broda Feeder Chair with a lap tray applied for meals.

A review of resident #027's progress notes from the past three months, indicated that the resident had specified behaviours, but no indication for the need of a Feeder Chair during meals were noted. A consent obtained for the use of a PASD from resident's SDM was not located in the records. Review of resident's care plan showed no interventions related to the use of a PASD in the form of a lap tray applied to a feeder chair during meal times.

On February 16, 2017, in an interview with RN #109, RN #109 indicated that the feeding chairs and lap trays were used only for an hour during meals while assisting residents with eating. It was not considered a restraint, that's why it was not always put in the care plan because the residents changed from day to day. RN #109 indicated that if it was a restraint they needed to have an order and everything in place.

Inspector #461 asked RN #109 how was the consent obtained from resident's family, and RN indicated the nurses usually reviewed the need for the feeder chair with family and obtained a verbal consent from them. RN #109 indicated there was no form filled out for residents when needing a feeder chair. Inspector asked RN #109 if she would consider the lap tray a PASD, RN reported that it was in fact a PASD because it helped assist residents during meals only, but it was perhaps not considered as a PASD, because the staff were always in the dining room monitoring. RN #109 further reported that if at some point, someone needed to use the chair, the nurses allowed the staff to use them. It was not always the same residents. RN #109 added that whenever the feeder chairs were needed, this was discussed with the families,on admission or when needed. The families were advised on admission, that on the One-North unit residents didn't have assigned seats, it depended on the day.

On February 16, 2017, in an interview with the DOC, she indicated that PASDs were devices used to assist residents with their daily living activities. The DOC indicated it was expected that the staff monitored, documented, and obtained consent from the SDM. Inspector #461 also inquired about the Form #38 that was mentioned in the PASD policy. The DOC indicated that the Form #38 outlined what device was being used, who in the interdisciplinary team were involved, if there were other restrains, other alternatives that had been considered, if the SDM had been consulted. The DOC indicated that currently the ADOC and RPN #110 were in charge of the RAI documentation and reviewing the residents' care plans related to PASDs.

On February 16, 2017 in an interview with RPN #110 and review of Form #38 "Referral for Restraint and/or PASD" - 200-05-02 Appendix II she indicated that this form was used

only on admission, but it was not kept in the chart when it needed to be archived. The home's expectation is that the need for the feeding chairs should be reviewed quarterly under the ADL RAP assessments.

On February 17, 2017, Inspector #461 spoke with the DOC. The DOC indicated that she had reviewed with the staff of the One-North Unit the care plans for residents #009, #026, and #027 related to the PASD in the form of feeder chairs with lap trays applied during meal times. The DOC indicated that she had spoken with the RN and RPN on the One North Unit and advised them about following the home's PASD policy. The DOC acknowledged there were gaps in the implementation of the PASD policy, and even the residents who did not use the feeder chair with lap tray very often, this should still be noted in the care plan as needed. The DOC also acknowledged that staff should be obtaining a consent from the residents' POA for the use of any PASD. The DOC indicated that more education was needed for the staff.

After observations, review of health records, and interviews with the staff, it was determined that the use of the PASD in the form of a Feeder Chair with lap trays applied during meals had not been consented by the substitute decision-maker of the residents #009, #026, and #027, with the authority to give that consent. [s. 33. (4) 4.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response was provided to the Resident Council within 10 days of receiving the advice, concerns or recommendations .

The Resident Council (RC) meeting minutes were reviewed for December 2016 and January 2017 and noted the following concerns from the RC.
December 2016 minutes, the residents indicated concerns with the delivery of their subscribed daily newspaper or Vista magazines and in addition a safety risk where residents were being left in the dining room to long after meals unsupervised.
January 16, 2017 RC meeting minutes indicate that responses to the the Dec. 20, 2016 were provided during this meeting. The residents brought concerns forward at this meeting regarding last minute menu changes at meal times and concerns with personal laundry return which the RC assistant reported to the appropriate supervisor.

On February 16, 2016 during an interview with the Resident Council President and review of the RC minutes he/she indicated that he/she does not receive a written response within 10 days related to concerns or recommendations. The RC president indicated that when concerns are brought forward he/she may receive a verbal response from the Resident Council Assistant and then the recommendation or concerns are discussed at the next meeting.

The Administrator was interviewed and indicated that related to staffing changes the Resident Council have not received a written response to concerns or recommendations within 10 days indicating that she would rectify the process to ensure a written response be provided to the RC within 10 days. [s. 57. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

On February 17, 2017 the Residents' Council President was interviewed and told inspector #531 that the Administrator attended a council meeting to discuss how the satisfaction survey had been developed and implemented in 2016; however she did not seek the advice of of the Residents' Council in developing and carrying out the satisfaction survey.

The Administrator was interviewed and indicated that although she discussed how the survey had been developed in conjunction with other local homes and how the survey would be conducted; she did not seek the advice of the Residents Council in the developing and carrying out of the satisfaction survey. [s. 85. (3)]

Issued on this 22nd day of March, 2017

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

Original report signed by the inspector.