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

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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
Jan 27, 2017	2016_378116_0015	032028-16	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

FAIRVIEW NURSING HOME
14 CROSS STREET TORONTO ON M6J 1S8

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

SARAN DANIEL-DODD (116), JUDITH HART (513)

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): November 14, 15, 16, 17, 18, 21, 22, 23, 24, 28, 29, 30 & December 1, 2016.

The following critical incident (CI) inspection was conducted concurrently with the RQI: Log# 027466-16 (related to abuse).

The following complaint (CO) inspections were conducted concurrently with the RQI:

Log# 008812-14 (related to Residents' Bill of Rights and Plan of Care)
Log# 030854-16 (related to nutrition and continence care).

During the course of the inspection, the inspector(s) spoke with residents and families, executive director (ED), director of nursing (DON), associate DON (ADON), registered dietitian (RD), maintenance manager, social worker, registered nursing staff, personal support workers (PSWs), housekeepers, substitute decision makers (SDMs), Residents' Council President and Family Council president.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care did not set out clear directions to staff and others who provide direct care to the resident.

On an identified date, a concern related to meal service and meal assistance for resident #008 was submitted to the Director. The resident no longer resides in the home.

A review of the written plan of care for resident #008 identified the resident was on a therapeutic and texture modified diet.

A review of the nutrition assessment on an identified date, by the registered dietitian (RD) for resident #008 indicated the resident was to receive a therapeutic and regular texture diet.

An interview with direct caregiver PSW #113 and registered staff #114 revealed resident #008 received a texture modified diet, which was not the most recent diet identified in the written plan of care, not setting out clear directions for the diet the resident was to receive.

An interview with registered staff #105 confirmed the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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, to be implemented voluntarily.

WN #2: 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 any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On an identified date, during the RQI inspection, resident #001 triggered for altered skin integrity relative to the previous minimum data set (MDS) assessment.

A review of resident #001's current written plan of care indicated he/she was at high risk

for impaired skin integrity.

A review of the MDS on an identified date, revealed resident #001 exhibited multiple areas of altered skin integrity. A review of the MDS on an identified date, showed one area of altered skin integrity.

The written plan of care on an identified date, documented altered skin integrity to three specified areas on resident #001's body.

A review of the medical record could not identify that skin and wound assessments had been documented by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

The home's policy entitled "Wound/Skin Care", identified a skin assessment using the Wound Assessment Tool will be performed when there is a change in the resident's health status that affects skin integrity. The assessment will be completed on a weekly basis by the registered team member. Any issue identified will be reviewed by the registered team member and suitable interventions, treatments, or needs will be addressed and documented in the care plan, TAR and wound care sheets as necessary.

Interviews with staff #117 and the skin and wound nurse confirmed that skin and wound assessments had not been documented for resident #001's altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration are implemented.

A review of resident #006's written plan of care indicated he/she was at high risk for impaired skin integrity and exhibited altered skin integrity to four identified areas of his/her body.

A review of the written plan of care and medication administration record (MAR) on an identified date, documented altered skin integrity on four identified areas of his/her body. A review of the progress notes on two separate dates, identified new area(s) of altered

skin integrity to specified location(s) on resident #006's body.

Interviews with the wound care nurse and registered dietitian confirmed that a referral was not made to the registered dietitian (RD) for the newly acquired altered skin integrity areas. The RD stated that a referral would be expected with these skin changes. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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 the plan, policy, protocol, procedure, strategy or system, was complied with.

On an identified date, resident #001's bed rails were observed to be raised when the resident was in bed.

A review of the MDS on an identified date, revealed bed side rails were used daily.

The current written plan of care indicated the personal assistance services device (PASD) application of two half bed rails were to be up when the resident was in bed, as per the family's request.

The policy for nursing care titled, "Restraint and PASD Procedures in Long-Term Care (LTC)," stated, the resident or POA has consented to the use of the PASD and the Consent Form has been reviewed, signed and dated annually.

The written plan of care indicated that a representative of resident #001 had requested that two half bed rails be engaged when the resident was in bed. A signed consent for the PASD use was not obtained at the time of the representative request.

An interview with the ADOC revealed the last PASD consent for bed rail use was discussed in the annual care conference on an identified date, an official consent was not obtained prior to the application of the bed rails, and confirmed the policy was not complied with for restraint and PASD procedures [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

On an identified date, the government stock medications were observed to be housed in the bottom drawer of an identified medication cart. An identified medication was observed to be expired.

A review of the Disposal of Discontinued Medications policy #02-06-20, indicated expired medications will be identified and separated from drugs that are available for administration to a resident, then destroyed and disposed of.

An interview with registered staff #100 and student nurse #101 verified the aforementioned medication had expired and registered staff #100 removed the medication from the cart.

An interview with the DON confirmed the medication was identified as expired two weeks earlier. Staff were requested at that time to remove the medication and the aforementioned medication was not removed from the medication cart as instructed, therefore the Disposal of Discontinued Medications policy that had been put in place was

not complied with. [s. 8. (1) (b)]

WN #4: 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 has failed to ensure that they respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

The Family Council questionnaire, completed by the Family Council president, revealed that when the licensee was advised of concerns or recommendations, a response in writing within 10 days from the licensee was not received by the Family Council.

Review of the Family Council minutes and an interview with the Family Council Assistant revealed that the current scheduling for the Family Council meetings are every three months. Review of the Family Council minutes for the year 2016 and an interview with the Family Council assistant revealed that the home provides a response to any concerns or recommendations made by the Family Council at the following scheduled meeting.

An interview with the Executive Director(ED) confirmed that the home initiated a new process whereby, responses are being communicated and documented during the meeting. The ED further confirmed that prior to the new process a written response was not provided within 10 days of receiving advice related to concerns or recommendations made by the Family Council. [s. 60. (2)]

WN #5: 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 Family Council in developing and carrying out the satisfaction survey.

The Family Council questionnaire, completed by the Family Council president, revealed the licensee did not consult with or seek the advice of the Family Council in developing and carrying out satisfaction surveys conducted by the Long-Term Care (LTC) home.

Interviews with the Family Council president, Family Council assistant, ED and a review of the Family Council minutes for 2015 and 2016 confirmed that the Family Council was not involved with developing and carrying out the home's satisfaction survey. [s. 85. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During stage one of the Resident Quality Inspection (RQI), resident #001, #002 and #003 triggered for room odour to be further inspected.

During the initial tour of the home, resident's rooms for #001, #002 and #003 had a lingering offensive odour. Observations continued on three separate dates and all rooms continued to have a lingering offensive odour.

On an identified date, inspector #116 observed staff #102 clean the washrooms for resident #001 and #002. An interview held with staff #102 revealed that these rooms required additional cleaning and the use of an identified cleaning agent due to the odours present in the washroom. Staff #102 confirmed that the odours were still present after the additional cleaning with the cleaning agent. Staff #102 indicated that he/she has not reported the offensive odours to the maintenance manager or management of the home.

Interviews and observations were made with the maintenance manager and ED who confirmed that presence of lingering offensive odours remained in resident's #001, #002 and #003 washrooms. An interview with the ED indicated that the home's current procedure for addressing incidents of lingering odours is not effective. [s. 87. (2) (d)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of resident #001's written plan of care indicated he/she exhibited altered skin integrity to an identified area.

On an identified date, the physician prescribed an identified medication to be administered at a prescribed frequency over an established period of time to the area of altered skin integrity.

A review of the medication administration record (MAR) and treatment administration record (TAR) showed that the medication was signed off in the TAR as administered at an identified time on two separate dates. The medication was not signed off as administered at any other date or time.

The progress notes were reviewed over a specified period of time, with registered staff # 105. The progress notes showed that on an identified date the medication was administered. No other entries in the progress notes were made confirming administration of the medication.

An interview with registered staff #117 confirmed the medication was not signed off in the TAR as administered, except for the dates previously identified.

An interview with registered staff #105 revealed that the medication was not signed off on either the MAR, TAR, or progress notes, except for the dates and times previously noted. Interviews held with registered staff #105, #117 and the ADOC confirmed that the medication prescribed was not administered to resident #001 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.