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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Performance Improvement and Compliance Branch

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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
Aug 22, 2014	2014_295556_0027	O-000757-14	Resident Quality Inspection

Licensee/Titulaire de permis

GEM HEALTH CARE GROUP LIMITED
470 RAGLAN STREET NORTH, RENFREW, ON, K7V-1P5

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

GROVES PARK LODGE
470 RAGLAN STREET NORTH, RENFREW, ON, K7V-1P5

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

WENDY PATTERSON (556), ANANDRAJ NATARAJAN (573), HUMPHREY JACQUES (599), PAULA MACDONALD (138)

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): August 11, 12, 13, 14, 15, 18, 19, 20, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Supervisor, Nutrition Manager, Housekeeping/Maintenance Manager, Registered Dietitian (RD), Pharmacist, Physiotherapy Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Personal Support Worker (BSO), Housekeepers (HSKP), Program Facilitator, Maintenance Personnel, Cook, Office Assistant, President of the Resident's Council, Chair of the Family Council, Residents, and Family Members.

During the course of the inspection, the inspector(s) toured resident care areas and non-residential areas, reviewed residents' health care records, reviewed infection control policies, environmental services policies, reviewed menus, zero tolerance of abuse and neglect policy, medication administration policies, continence and bowel management program, pain management protocol program, fall prevention program, internal incident & investigation documentation, external service provider service agreement and service records, reviewed resident personal equipment repair log, observed residents meal service, and observed medication administration.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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.) 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Ontario Regulation 79/10, s. 48 (1) states that every licensee of a long-term care home shall ensure, that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
4. A pain management program to identify pain in residents and manage pain;
Ontario Regulation 79/10, s. 30. (2) states every licensee of a long-term care home shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any assessments and reassessments for Resident's #002, #004, and #006 were documented.

During an interview Staff member #S100 reported that Resident #002 experienced an unwitnessed fall on a specified date.

A review of Resident #002's health care record indicates that Resident #002 ambulates independently, and has been diagnosed with a specified condition. His/her care plan indicates he/she has an unsteady gait and is at risk for falls.

In an interview the DOC stated that the physiotherapy staff do post fall assessments following all resident falls.

In an interview Physiotherapy Assistant #S111 stated the Physiotherapist is in the home twice per week and the Physiotherapist and the Physiotherapy Assistant together do a post fall assessment on every resident who has experienced a fall. #S111 further stated that they use the quarterly physio assessment tool to do the post fall assessments, and the documentation is done on Point Click Care (PCC).

Staff member #S111 reviewed Resident #002's health care record with Inspector #556 and was not able to find documentation of the post fall assessment from the fall on the specified date. #S111 further stated that she/he knows the resident was assessed because she/he was present when the Physiotherapist assessed the resident even though the assessment was not documented.

In an interview Resident #004 stated that he/she experienced pain on a daily basis

and that the pain medication given by the staff does not always alleviate the pain.

In an interview staff member #S132 stated that Resident #004 frequently complains of pain.

A review of Resident #004’s health care record indicated that there was a physician’s order for a narcotic every 12 hours for pain as required.

A review of the narcotic control records indicated that Resident #004 received the narcotic for pain 20 times in January, 60 times in February, 51 times in March, 60 times in April, 63 times in May, 59 times in June, 32 times in July, and 30 times between August 1 and August 18, 2014.

In an interview registered staff member #S119 stated that the Registered Staff do formal Pain assessments quarterly, and an informal assessment is done any time that pain medication is being administered. #S119 further stated that there is a pain assessment tool in PCC that is used when doing the formal assessments, and there is also a paper tool which could be used and would be filed in the resident's health care record.

In an interview the Clinical Supervisor stated that the expectation is that Registered Staff will do an informal pain assessment every time a resident is experiencing pain, formal pain assessments are to be done at least quarterly, and the pain assessment could be done either on the paper tool, or using the electronic pain assessment tool in PCC.

The Clinical Supervisor reviewed Resident #004's health care record back to February 2014 with Inspector #556 and was not able to locate a completed pain assessment. The Clinical Supervisor further stated that she thinks that pain assessments are being done for Resident #004, however the assessments are not always being documented.

During stage 1 of the Resident Quality Inspection Resident #006 triggered through the homes MDS submissions for worsening pressure ulcer. A review of the MDS assessments from February 2014 and May 2014 stated that the resident had a stage 3 pressure ulcer.

In an interview Registered staff member #S102 stated that resident #006 currently has

a very small open area.

In an interview staff member #S132 stated that Resident #006 has had a pressure ulcer for at least 6 months. #S132 further stated that it recently got a lot better but it has now opened again.

In an interview the Clinical Supervisor stated that it is the expectation that Registered Staff do a weekly wound assessment on every resident who has a wound, and the assessments are documented using the wound assessment tool in PCC.

The Clinical Supervisor reviewed Resident #006's health care record back to February 2014 with Inspector #556 and was not able to locate weekly wound assessments for the stage 3 pressure ulcer. The Clinical Supervisor further stated that the wound would have been assessed with each dressing change however the assessments were not always being documented. [s. 30. (2)]

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 assessments related to pain, skin and wound, and falls are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the personal health information of resident #024, #025, and #026 was kept confidential.

On August 19, 2014 while registered staff #S117 was administering medications Inspector #599 observed registered staff #S117 discarding the empty medication pouches containing personal health information for residents #024, #025, #026 into a garbage container secured to the side of the medication cart.

In an interview #S117 stated the garbage from the container on the medication cart is then disposed of into the general garbage for the home. During an interview registered staff #S106 stated this is the normal practice for disposing of empty medication pouches.

The Home has failed to ensure the right of residents to have his or her personal health information kept confidential. [s. 3. (1) 11. iv.]

WN #3: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that 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 supervised by staff.

During the initial tour upon entrance to the home on August 11, 2014, LTCH Inspector #599 observed several doors to linen rooms and soiled utility rooms (non-residential areas) to be unlocked throughout the home.

On the morning of August 12, 2014, LTCH Inspector #138 completed observations of the Gem Wing within the home and observed the following with respect to doors leading to non-residential areas:

Room 421 "Clean Linen" – the door to this room was closed but not locked and was able to be opened by the inspector. It was noted by the inspector that this room was a storage room for linen and also that there was no call bell in this room. This room was observed to be in a corridor frequented by staff but not constantly supervised.

Room 423 "Soiled Linen" – the door to this room was closed but not locked and was able to be open by the inspector. It was noted by the inspector that there were resident catheter bags and cleaning equipment in this room and also that there was no call bell. This room was observed to be in a corridor frequented by staff but not constantly supervised.

Room 428/430 "Wheelchair Repair and Storage" – this door was closed but unlocked and was able to be opened by the inspector. Inside this room was a variety of mobility equipment such as wheelchairs. There was an inside room which was noted to be locked. It was observed that there was no call bell in the outside room that was

accessed by the inspector. This room was observed to be in a quiet corridor often unattended by staff.

On August 13, 2014 it was first observed by LTCH Inspector #138 that room 447 "w/c storage" off the side of the Crystal dining room in the Gem link was propped open with a dining room chair and remained this way throughout the course of the inspection. This storage room contained ceiling tiles, linens, extra chairs and tables. There was no call bell inside this room.

On August 15, 2014, LTCH Inspector #138 conducted a tour of the entire building and again found several doors leading to non-residential areas to be unlocked. The inspector was able to reconfirm observations of doors on the Gem Wing as previously described for August 12/13, 2014 and also made the following observations:

Sapphire wing -
"Linen" room (between rooms 201 and 203) door was closed but unlocked. Inside was observed to have linen supplies and no call bell. It was also observed by the inspector that the room was not constantly supervised by staff.

Emerald Wing -
"Janitor – Utility" room (between room 104 and 106) door was closed but not locked. Inside was a hopper, three commodes, and vinegar. No call bell was observed in this room. It was also observed by the inspector that the room was not constantly supervised by staff.

The "Beauty Parlor" door was observed to be propped open and unstaffed that day. There is no call bell in this room. It was also noted that the Beauty Parlor is outside the Nursing Station in the centre area but it was observed by the inspector that the staff were not consistently at the Nursing Station to supervise the Beauty Parlor when the door was open.

Ruby Wing-
"Linen" room (between room 303 and 305) door was closed but not locked. Inside was observed to have linen supplies and no call bell. It was also observed by the inspector that the room was not constantly supervised by staff.

"Janitor - Utility" room (between rooms 308 and 306) door was closed but unlocked.

Inside the room was a hopper, several commodes, bagged dirty linen, vinegar supplies. No call bell was observed in this room. It was also observed by the inspector that the room was not constantly supervised by staff.

LTCH Inspector #138 spoke with a personal support worker, #S101, who said that she was a long term employee in the home and stated that the doors to the linen room and janitor-utility room on the Ruby wing are always unlocked and have been unlocked for years.

On August 18, 2014, LTCH Inspector #138 spoke with a maintenance personnel, #S120, regarding non-residential areas. The maintenance personnel stated that storage rooms including wheelchair storage, utility-janitor rooms, and linen and soiled linen rooms, were considered non-residential areas and, additionally, residents should not access the Beauty Parlor without the presence of staff. The maintenance personnel further stated that he has been at the home for several years and that these doors have been unlocked as long as he has been in the home. [s. 9. (1) 2.]

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 failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

LTCH Inspector #138 was completing an observation of the residents' spa room on the Sapphire wing and noted that the tub system contained in the spa room consisted of an older model Century brand tub/lift that was green in colour. The inspector further observed the tub/lift system and noted that the surface of the seat of the chair

lift was heavily cracked in a criss-cross pattern throughout the entire seat surface creating a rough surface for residents to sit on. It also created a surface that is no longer intact and no longer conducive for proper cleaning and sanitizing. The inside tub surface was also heavily cracked in a criss-cross pattern along the entire bottom and lower sides of the tub. Some of this surface coating was chipped away exposing the fibreglass-like material underneath resulting in a surface that is no longer conducive for proper cleaning and sanitizing.

LTCH inspector #138 spoke with a maintenance personnel, #S120, regarding the maintenance of the Century tub/lift system. The maintenance personnel stated that the tub/lift system was not maintained through the home but was instead maintained by an external service provider. The inspector spoke with the home's Administrator who provided a copy of the service agreement for the home's tubs. The inspector further requested a copy of the last report that outlined the status of the home's tubs and lifts. The Administrator provided a copy of a service call report dated 10/28/13 and stated to the inspector that the external service provider found normal wear and tear on the Century tub/lift. The inspector reviewed the service report provided and noted that there was no mention of work performed or the status of the Century tub/lift. The inspector further examined the current service agreement and noted that the Century tub/lift was not included in the agreement. The inspector spoke with the Administrator on August 19, 2014 regarding the exclusion of the Century tub/lift on the service agreement and she responded by saying that she would contact the external service provider and will arrange to have the Century tub/lift included in the service agreement.

On August 20, 2014, LTCH Inspector #138 viewed the tubs and lifts on the service agreement once again and noted that each tub and lift on the service agreement were marked with a sticker from the external service provider indicating that the tub or lift had been serviced in 2013 by an authorized technician (corresponding with the service report of 10/28/13 previously provided by the Administrator). The Century tub/lift had a similar sticker however the service date was 2011. The inspector spoke with the Administrator regarding the stickers on the tubs and lifts and she stated that these stickers would correspond to the service dates and that the sticker of 2011 on the Century tub/lift would indicate the last service provided. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items.

On August 11, 2014 Inspector #599 observed the following unlabelled personal care items:

An unlabelled hair brush with visible hair, two unlabelled safety razors with visible debris, and an unlabelled tube of calmoseptine were observed in the top drawer of a cabinet in the shared spa room on the Sapphire Wing.

An unlabelled bar of soap, three unlabelled safety razors with visible debris, and two unlabelled and rusted nail clippers were observed in a cupboard in the shared spa room on the Gem Wing.

In a shared bathroom between two specified rooms an unlabelled tooth brush, bar of soap, used deodorant stick, and denture cup were observed.

In a shared bathroom between two specified rooms two unlabelled toothbrushes were observed.

In the shared bathroom of a specified room an unlabelled bar of soap was observed.

In an interview the Director of Care (DOC) stated that it was expected that all personal items be labelled. [s. 37. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed ensure that the planned menus are offered and available at each meal and snack.

On August 11, 2014, during Stage 1 of the Resident Quality Inspection (RQI), it was observed by LTCH Inspector #138 during a lunch meal observation in the Crystal Dining Room that the pureed texture modified meal offered to a resident did not correspond with the posted menu for that meal. LTCH Inspector #138 spoke with the food service worker, #S123, regarding the pureed texture modified menu and the food service worker stated that the resident was provided a Trepuree entrée (a commercially prepared frozen and reheated puree entrée that generally consists of a vegetable, potato, and meat portion) but was not able to identify the flavour of Trepuree that was provided to the resident. The food service worker stated that there was only one resident in the Crystal Dining Room who received a pureed textured modified diet and that the resident's diet was accommodated with Trepuree entrees. The food service worker further stated that the cooks made the decision each day as to which flavour of Trepuree entrées were to be served.

On August 18, 2014, LTCH Inspector #138 obtained a copy of the pureed menu from the main kitchen and observed that the pureed texture modified meal provided at lunch that day was not according to the menu but instead was a choice of two flavours of Trepuree entrées. LTCH Inspector #138 spoke with the Nutrition Manager who stated that the home has a pureed texture modified menu as there are several residents in the home requiring a pureed modified texture diet. The Nutrition Manager further stated that the home is not currently following the pureed texture modified menu and instead provides Trepuree entrées to residents who require a puree texture modified diet. The Nutrition Manager stated that it was a goal of the department to implement the home's pureed texture modified menu in the next menu cycle starting in approximately six weeks. [s. 71. (4)]

WN #7: 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 seek the advice of the Residents' Council in developing and carrying out the annual satisfaction survey.

Resident #021, President of the Residents' Council, stated that he/she has been participating in the Residents' Council for three years and does not remember the council being asked for advice in developing and carrying out the satisfaction survey during that time.

Staff member #S114 stated that there is a satisfaction survey conducted annually in the home, and staff member #S113 is the lead on that project.

Staff member #S113 Program Facilitator stated that she/he has been the lead for the satisfaction survey, and Quality Improvement generally, in the home since 2011 and is not aware of the home specifically seeking the advice of the Residents' Council in developing and carrying out the survey during that time. LTCHA 2007, c. 8, s. 85 (3) [s. 85. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.

On August 11, 2014 at 11:00am while touring the home Inspector #573 observed an unlocked and unsupervised medication room near a resident lounge area between Sapphire wing and Emerald wing.

Inspector #573 spoke to registered staff #S102 who stated that the medication room is supposed to be locked at all times.

On August 12, 2014 at 09:43am Inspector #573 observed the same medication room unlocked and unsupervised.

In an interview registered staff #S103 stated that the medication room is to be kept locked at all times when not in use.

In an interview the DOC stated that after Inspector #573 twice brought the concern about the unlocked medication room to their attention it was identified that there was a problem with the medication room door lock, and further stated that the lock had been repaired on August 13, 2014. [s. 130. 1.]

WN #9: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection control program.

While observing medication administration Inspector #599 observed registered staff member #S117 performing a procedure to resident #024. Staff member #S117 failed to perform any hand hygiene before or after the procedure. Immediately following the procedure #S117 started preparing the medications for resident #025. In the process she/he removed tablets from two separate bulk containers with his/her fingers.

During the medication administration for residents #024 and #025 staff member #S117 failed to participate in the implementation of the infection control program as it relates to hand hygiene. [s. 229. (4)]

Issued on this 22nd day of August, 2014

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