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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2015	2015_275536_0015	H-003050-15	Resident Quality Inspection

Licensee/Titulaire de permis

KING NURSING HOME LIMITED
49 Sterne Street Bolton ON L7E 1B9

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

KING NURSING HOME
49 Sterne Street Bolton ON L7E 1B9

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

CATHIE ROBITAILLE (536), DARIA TRZOS (561), JESSICA PALADINO (586), KATHLEEN MILLAR (527), THERESA MCMILLAN (526)

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 19, 20, 21,24. 25. 26. 27. 28, 31 September 1, 2, 3 and 4, 2015

During this inspection a Follow Up Inspection was completed related to previously identified Directors Orders and Compliance Orders from the Resident Quality Inspection (RQI) number 2011_071159_0012.

The following Directors Orders (D.O) and Compliance Orders (C.O) where identified as previously complied:
C.O #004/#904, D.O #002/#905(replacing C.O. #005), C.O #006/#908, C.O #007/#909, C.O #008/#910, C.O #012/#914, C.O #016,
C.O #017, C.O #018, C.O #019/#905 and C.O #020.

The following Director’s Orders (D.O) Compliance Orders (C.O) where complied during this Resident Quality Inspection (RQI):
D.O #001(replacing C.O. #001/#901), C.O #002/#902, C.O #003/#903, C.O #009/#911, C.O #010/#912,
D.O #003 (replacing C.O #011/#913), C.O. #013/#915, C.O #014/#916, C.O #015/#917, C.O #021, C.O #907 and C.O #906.

During this Resident Quality Inspection(RQI), Complaint Inspections: H-001724-14 and H-001749-14 and Critical Incident System (CIS)Inspections: H-001572-14, H-002368-15, H-002344-15, H-002648-15, H-002675-15, Log# 018999-15, Log# 002734 -15 and Log# 022947-15 were conducted concurrently. There were findings of non-compliance in both the Complaints and CIS inspections.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s)spoke with residents, family members, Personal Support Workers(PSW), Registered Nurses(RN) and Registered Practical Nurses (RPN), Resident Assessment Instrument(RAI)Co-Ordinator, Environmental Manager, Janitor, housekeeping staff, Director of Resident and Family Services, Staff Educator/QI Co-Ordinator, Director of Care(DOC), Associate Director of Care (ADOC), Bookkeeper, Office Co-Ordinator and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #001	2014_278539_0022	536

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #034 had a Falls Risk Assessment completed on an identified date, which identified the resident was at high risk for falls. The plan of care was reviewed; and identified, the resident required specific interventions, as one of the falls prevention strategies. The resident was observed in bed on four occasions in August 2015, and one specified intervention was not in place. The Registered Staff and Personal Support Workers (PSW's) were interviewed and confirmed, the resident required this intervention when in bed to prevent falls.

Resident #044 had a Falls Risk Assessment completed on an identified date. The assessment identified that the resident was at high risk for falls. The plan of care was reviewed; and identified, the resident was to have specific interventions identified in their plan of care in place. The resident was observed on four occasions in August 2015, and did not have these interventions in place. The Registered Staff and PSW's were interviewed, and confirmed the falls prevention strategies for resident #044. They also confirmed, that the resident's identified interventions were not in place. [s. 6. (7)]

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 and ensuring that the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who were incontinent had an individualized plan of care.

The homes policy "Continence Guidelines for Care", policy number: VII-E-10.00; originally issue: June 2010; current revision: November 2013, stated: All Nursing Staff will adhere to the resident's individualized care plan which will include the following: scheduled times for checking; changing, and toileting residents. A clinical record review was completed for resident #019, #028 and #029. The plan of care for resident #019, #028 and #029 stated: specific interventions as identified for each resident. The RAI Co-Ordinator and the Staff Educator/QI Co-Ordinator confirmed that these were not individualized plans. The home failed to ensure that residents who were incontinent had an individualized plan of care to direct staff providing care on toileting protocols. [s. 51. (2) (b)]

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 and ensuring that residents have an individualized plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs complied with manufacturer’s instructions for expiration dates and storage of the drugs.

The Long Term Care (LTC) Inspector observed that there were expired drugs in the government stock and in the home's vaccine fridge. The expired drugs included:

- Eighteen bottles of an identified drug, which expired on an identified date,
- Seven bottles an identified medication, of which two bottles expired on an identified date, and five bottles expired on an identified date,
- One identified adhesive, which expired on an identified,
- Three boxes of an identified medication, which expired on an identified date,
- Two vials of an identified drug, which expired on an identified date,
- Sixteen vials of an identified drug, which expired on an identified date, and
- Four of an identified drug, which expired on an identified date.

The home's policy called "Handling of Medication-Expiry and Dating of Medications", policy number: 5-1; dated: January 2014, directed Registered Staff to examine the expiry date of all medications on a regular basis, and to remove any expired medications from stock, and order replacement if necessary. All expired vaccine was to be returned to Public Health.

The Director of Care(DOC) was interviewed and confirmed, that the Registered Nurses (RNs) on the night shift were to check the government stock monthly; and were expected to remove any expired medications from the home's stock and order replacements, if necessary. [s. 129. (1) (a) (iv)]

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 and ensuring that all drugs are checked for expiry dates and comply with manufacturer's instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (4) No licensee shall,
(a) hold more than $5,000 in a trust account for any resident at any time; O. Reg. 79/10, s. 241 (4).
(b) commingle resident funds held in trust with any other funds held by the licensee; or O. Reg. 79/10, s. 241 (4).
(c) charge a resident, or a person acting on behalf of a resident, a transaction fee for withdrawals, deposits, or anything else related to money held in trust. O. Reg. 79/10, s. 241 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that transaction fees for are trust accounts were not charged to money held in trust.

On an identified date in 2015, the Long Term Care(LTC) Inspector met with the Bookkeeper to review bank statements for the Trust Account for residents in the home. The LTC Inspector noted that a bank service fee was being charged monthly to the trust account. The Bookkeeper was asked to provide the LTC Inspector with the last reconciliation to the Trust Account for these bank service fees. On an identified date in 2015, the LTC Inspector was given a copy of a cheque reconciling service fees for an identified year(s). The Bookkeeper confirmed that a reconciliation had not taken place since an identified date. This was also confirmed by the Administrator. [s. 241. (4) (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 and ensuring that transaction fees for trust accounts are not charged to money held in trust, to be implemented voluntarily.

WN #5: 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 failed to ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) was in compliance with and was implemented in accordance with applicable requirements under the Act; and (b) was complied with.

Resident #019, #034 and #044, had Falls Risk Assessments conducted on identified dates. The clinical records were reviewed; and the assessments identified, that all three residents were high risk for falls. The home's policy called "Falling Leaf Program", policy number: VII-G-60.00-sup; originally issued: June 2003, current revision: September 2011, directed staff to document the risk level on the written plan of care; that the residents' would have a red leaf logo system initiated; and the logo would be place alongside their name plate outside their bedroom door; on their walker or wheelchair, and on the top of their bed. The Registered Staff were interviewed on each unit, and only one of the Registered Practical Nurses (RPN's) were able to identify, that residents at high risk for falls would be on the Falling Leaf Program. The registered staff were not able to identify if the red leaf logo system was initiated for resident #019, #034 and #044. During the observation of the three residents over a four day period on identified dates, the Long Term Care (LTC) Inspector was not able to locate the red leaf logo at the top of residents bed; on their wheelchair, or alongside their name plate outside their bedroom door. The Registered Staff and the Personal Support Workers (PSW's) were interviewed; and confirmed, that the red leaf logo was not implemented for resident #019, #034 and #044 as expected, and they were not in compliance with their Falling Leaf Program policy and procedure. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, made a response to the person who made the complaint, indicating: i. what the licensee had done to resolve the complaint; or, ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

The daughter of resident #025 made a complaint to the home on an identified date, and subsequently telephoned the Director of Care(DOC) on an identified date. The complainant identified, that they had not heard back from the home regarding resolution of their complaint. The Long Term Care (LTC) Inspector reviewed the home's complaint log; and identified, the complaint was documented as responded to immediately on an identified date, and that the response was made to the complainant and the resident's Power of Attorney (POA). However, based on the interviews with the complainant and the POA, they identified no one from the home had contacted them, and the home had yet to contact them of the outcome of their investigation. The LTC Inspector reviewed the home's Risk Management notes in Point Click Care (PCC),and reviewed the resident's progress notes. There was no documentation in the Risk Management section of PCC or in the resident's clinical record. A review was completed of the home's policy "Complaints - Response Guidelines", policy number: VI-G-10.00; originally issued: March 1997; current revision: July 2015, which directed the Administrator to conduct and document an internal investigation; contact complainant, and provide actions taken to resolve the complaints. The Administrator and DOC were interviewed, and they were unable to provide any documented investigative notes related to the complaint; they were unable to confirm the results of the investigation; and they were unable to confirm who had notified the complainant of the results of the investigation. [s. 101. (1) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident under subsection (1), (3) or (3.1) within 10 days in writing.

The home submitted an identified number of Critical Incident System (CIS) Notifications to the Director between identified dates, in which amendment requests were not responded to by the home. This was confirmed by the Director of Care (DOC). [s. 107. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the results of the annual evaluation and of any changes that were implemented.

The home's Professional Advisory Committee minutes were reviewed and identified the interdisciplinary team's review of the effectiveness of the medication management system and recommendations to improve the system. The Director of Care (DOC) was interviewed and identified the home completes quarterly and annual evaluations of the medication management system at the Professional Advisory Committee; however, they did not keep a written record of the results of the annual evaluation and of any changes that were implemented. The Administrator also confirmed, there was no written record of the results of the annual evaluation of the home's medication management system and the improvements that were implemented. [s. 116. (5)]

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 failed to ensure that staff participated in the implementation of the infection prevention and control program.

On an identified date, during the initial tour of the home the following observations were made:

i) A cart found in the tub room on an identified floor, contained unlabeled communal items,
ii) A cart found in the tub room on an identified floor, contained unlabeled communal items. A Personal Support Worker(PSW) present when this observation was made stated, that they would use one of the identified items for a specific task. The PSW also stated, that the identified item should be stored in the clean utility room soaking in antiseptic. The PSW left the tub room without removing the scissors. [s. 229. (4)]

Issued on this 16th day of September, 2015

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

Original report signed by the inspector.