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

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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 23, 2017	2016_544527_0020	033783-16	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

KATHLEEN MILLAR (527), HEATHER PRESTON (640), SAMANTHA DIPIERO (619)

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): December 9, 12, 13, 14, 15, 16, 19 and 20, 2016.

During this inspection the following Critical Incidents and Complaints were inspected:

Complaint:
Log #035336-16, Information line (IL) #42142-HA related to weight loss, food, issues with room mate and retaliation (also linked to this complaint was Log #08288-16)

Critical Incidents (CIS):
Log #023864-15, CIS #0901-000035-16 related to a fall
Log #028421-15; CIS #0901-000040-15 related to resident to resident abuse
Log #032802-15; CIS #0901-000041-15 related to visitor to resident abuse
Log #035815-15; CIS #0901-000042-14 related to alleged staff to resident abuse
Log #010278-16; CIS #0901-000005-16 related to fall
Log #018389-16; CIS #0901-000001-14 related to fall
Log #026546-16; CIS #0901-000008-16 related to resident to resident abuse
Log #034293-16; CIS #0901-000014-16 related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Acting DOC, the Assistant Director of Care (ADOC), the Environmental Manager, the Dietary Manager, the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, the Director of Resident Care Programs and Services, the Behavioural Support Organization (BSO), the Administrative Assistant (AA), the residents, the family members, the registered nurses (RNs), registered practical nurses (RPNs), the personal support workers (PSWs), the dietary aides, and the housekeeping aides.

During the course of this inspection, inspectors toured the home; observed residents and staff; reviewed health records, policies and procedures, training files, meeting minutes, housekeeping audits, annual program evaluations, complaint logs, and critical incident logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **11 WN(s)**
- **6 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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A review of resident #015's clinical health record indicated their written plan of care dated November 2015, was not based on the November 2015, bladder and bowel continence assessment. The bladder and bowel continence assessment identified the resident was continent for bladder and bowel. Coding for the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment also completed in November 2015, identified the resident was continent of bladder and continent of bowels.
PSW #115 and RPN #114 were interviewed and they were not aware that the resident was assessed as being continent of bladder when admitted and up to December 2016. They identified the resident had worn continence products since they were admitted. RPN #114 indicated that if the resident was continent that they would have implemented restorative interventions to ensure the resident was able to maintain their continence, and that the bladder and bowel continence assessment, RAI-MDS, and written plan of care were confusing.
Information on the resident's written plan of care was inconsistent with the assessments

completed in November 2015.
The written plan of care for resident #015 did not provide clear directions to staff related to the resident's continence care. [s. 6. (1) (c)]

2. 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.

On March 11, 2016, as documented by the home in CIS Log #010278-16, staff assisted resident #023 with a transfer. Staff did not remain with the resident. The resident attempted to self-transfer and sustained an injury. The written plan of care dated January 2016, directed staff to remain with the resident.
RPN #109 confirmed that resident #023's plan of care directed staff to remain with the resident. Interview with the Acting Director of Care, RN #110, confirmed that the plan of care for resident #023, directed staff to remain with the resident, and that staff did not remain with as directed on the written plan of care, which resulted in the resident having a fall with injury.
The care for resident #023 was not provided as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and revised at least every six months and when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #003 had a history of mobility issues, which required the use of a wheelchair and the resident used products due to incontinence. A review of the resident's plan of care last updated October 2016, indicated that the resident was at high risk for altered skin integrity. A review of the weekly skin and wound assessment initiated in October 2016, indicated that resident #003 was assessed as having altered skin integrity. Interviews with RPN #105 and RN #100 both indicated that at the time of inspection, they were previously unaware of the resident's altered skin integrity. RN #100 stated that when there was a change in the resident's condition, that registered staff were responsible for updating the resident's written plan of care to communicate the planned care for the resident to other staff, and indicated that no changes were made to resident #003's written plan of care to include treatments and interventions for the resident's altered skin condition.
The home's policy titled, "Skin and Wound Care Management Protocol", policy # VII-G-10.80, last revised April 2016, stated, "with a resident exhibiting altered skin integrity, the registered staff will update the plan of care, including the Treatment Administration Record and care plan as appropriate."

Interview with Administrator confirmed that registered staff were responsible for updating the written plan of care as required and confirmed that resident #003's written plan of care was not revised when the resident's care needs changed. [s. 6. (10) (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 to ensure the care set out in the plan of care provided clear directions, was provided to residents as specified in the plan, and to ensure that the resident was re-assessed and the plan of care reviewed and revised at least every six months and when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: 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 required 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, (b) was complied with.

The home's policy titled, "Head Injury Routine", policy # VII-G-10.40, and last revised January 2015, stated, "the registered staff will ensure Head Injury Routine (HIR) will be initiated on any resident who has sustained or suspected of sustaining a head injury".
In March 2015, resident #025 exhibited responsive behaviours towards resident #027. The resident to resident abuse was witnessed by staff.
Interview with PSW #106 indicated that when a resident had an injury to the head, that a head injury routine would be initiated. Interview with RN #110 indicated that resident #027 suffered no physical injury or any other changes in the condition of their skin from the altercation with resident #025, and confirmed that a head injury routine should have been initiated as resident #027 was struck on or about the head.
On review of resident #027's health record, the LTCH Inspector was unable to locate a Head Injury Routine flow sheet for this resident.
Interview with the Administrator confirmed that this policy was integrated into the Falls Prevention program in the home, which the home was required to have policies in place as per the Long Term Care Home Act, 2007. The Administrator also confirmed that the staff did not follow the home's head injury routine policy after resident #027 was struck by resident #025. [s. 8. (1) (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 to ensure that where the Act or this Regulation required 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, (b) was complied with, to be implemented voluntarily.

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 were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

In December 2016, during the initial tour of the home the LTCH Inspector #619 identified that the soiled utility room located on one of the resident units was open and unlocked. LTCH Inspector observed that the door had a punch code type lock, and was slightly ajar when initially observed. LTCH Inspector was able to close and lock the door after observations were made.
Interview with PSW #106 indicated that the room was considered a non-residential area because it was used to store cleaning and disinfecting solutions, soiled linens, and other soiled items. Interview with PSW #106 confirmed that the doors to this room were to be closed and locked at all times and indicated that the doors were not closed properly to prevent entry without an access code.
Interview with the Environmental Manager indicated that this type of room was a non-residential area and should be locked at all times because the rooms contained cleaning products that could be harmful to residents if they entered the room unsupervised.
Interview with the Administrator confirmed that the doors to the these rooms, which was a non-residential area, were required to be locked and secured at all times. [s. 9. (1) 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 the following rules were 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 were not being supervised by staff, to be implemented voluntarily.

WN #4: 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 failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #003 developed altered skin integrity that were initially assessed with the use of a clinically appropriate tool by a registered staff member in October 2016. On review of the residents health record, the resident received two assessments; the initial assessment at the beginning of October 2016, and the second at the end of October 2016.
Interview with PSW #106 stated that the resident's altered skin integrity was nearly resolved at the time of inspection, with only a small area remaining. Interview with RPN #105 indicated that when there was a change in a resident's skin condition that registered staff must initiate a weekly skin assessment to monitor, until the altered skin condition was resolved, and indicated that this was not completed for resident #003.
A review of the home's policy titled "Skin and Wound Care Management Protocol", policy # VII-G-10.80, last revised April 2016, stated, "With a resident exhibiting altered skin integrity, the registered staff will initiate a weekly skin assessment".
Interview with the Administrator confirmed that the registered staff were responsible for initiating weekly skin assessments and conducting the skin assessments until the altered skin integrity was resolved. The Administrator confirmed that the staff failed to complete weekly skin assessments for resident #003. (619) [s. 50. (2) (b) (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 to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: 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 steps were taken to ensure the security of the drug supply including restricting access to these areas only to persons who may dispense, prescribe, or administer drugs in the home and the administrator.

In December 2016, a garbage bag containing expired or discontinued non-narcotic medications was identified in the Director of Care's office. The bag identified contained many non-narcotic medications in plastic packaging.
Interview with the Administrative Assistant (AA) indicated that several persons had keys that would open the DOC's office door including, the DOC, ADOC, Administrator, and Administrative Assistant. In the interview, the AA confirmed that they were not a registered staff member and do not have the ability to dispense, prescribe, or administer drugs in the home.
Interview with the Administrator confirmed that the above mentioned persons in the home had access via key to the DOC's office. The Administrator confirmed that the Administrative Assistant should not have had access to the DOC's office as it was used as a storage location for discontinued or expired medications. [s. 130. 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 steps were taken to ensure the security of the drug supply, including the following: 1. All areas where drugs were 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, to be implemented voluntarily.

WN #6: 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 all staff participated in the implementation of the infection prevention and control program.

In December 2016, during the initial tour of the home, two home areas were identified as having unlabelled, used personal hygiene products in the spa tub and shower rooms. On one of the home areas in the tub and shower room, the LTCH Inspector observed the following used and unlabelled personal hygiene products: two (2) black combs, two (2) stick deodorants, and one (1) disposable razor. On another home area in the tub and shower room, the LTCH Inspector observed the following used and unlabelled personal hygiene products: four (4) disposable razors.
Housekeeping staff confirmed that these items should be labelled in accordance with the homes infection prevention and control policy. The home's policy titled "Clothing Care & Personal Effects", policy #VII-C-10.10, and last revised January 2015, directed staff to ensure that, "all personal items must be labelled with resident's name".
Registered Practical Nurse (RPN) #105 confirmed that personal hygiene items should be labelled in accordance with the home's infection prevention and control policy.
Interview with the Administrator confirmed that staff were responsible for labelling resident hygiene products and confirmed that staff did not participate in the homes infection prevention and control practices. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: 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 failed to ensure that the residents rights to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act.

In December 2016, while observing medication administration, the LTCH Inspector observed the narcotic administration record binder was left on top of the medication cart. On observation one narcotic count sheet was identified as standing out higher than the binder height and the LTCH Inspector was able to identify the name, room number, and medications of resident #032.
Interview with RPN #101 indicated that the narcotic binder should be locked in the medication cart when not in use. Interview with the Administrator confirmed that RPN #101 failed to protect the personal health information of resident #032. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 4. Vision.

During inspection of a critical incident related to a fall for resident #022, a review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessments dated June and August 2015, identified resident #022's vision to be impaired.
Review of the Fall Risk Assessments dated June and August 2015 identified the resident's vision to be impaired. Review of the "Falls Prevention" policy, number VII-G-30.00, including attachment, "Falls: Risk Factors & Related Interventions", attachment #VII-G-30.00(a), directed staff to include interventions for impaired vision, on the plan of care. Review of the written plan of care dated June and September 2015, did not include interventions related to impaired vision.
During an interview of RN #116, the staff confirmed the focus for impaired vision was not included in resident #022's plan of care, but should have been included. The Acting Director of Care, RN #110 confirmed resident #022's impaired vision was not included in the plan of care and that it was the expectation of the home that impaired vision be included in the resident plan of care. [s. 26. (3) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the "Quality Management – LTC Program/Committee Evaluation Tool for the Fall Prevention Program" identified that no dates were included for the summary of changes made, new evidence based best practices to be implemented and the goals of re-education of the staff about all fall related policies and procedures. The Administrator confirmed that it was the expectation of the home to include the dates of the summary of changes made, implementation dates of new practices and the goal dates for re-education of staff. [s. 30. (1) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had and that the staff of the home complied with, (a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

The home's "Cleaning Procedures" policy, # XI-I-10.40, and revised January 2015, directed staff to follow the cleaning schedule and complete the assigned cleaning. The cleaning schedule identified as "Attachment" XI-I-10.40(a) directed staff to thoroughly clean all equipment removing all food particles and stains every Wednesday.
Observation of the dining room on one of the resident units in December 2016, included equipment used for meal service in the dining room. The first shelf of the cart had four cracks which contained debris. All shelves were soiled and had dried spills to include the edges of each shelf. Observation of the same dining room a second time in December 2016, identified that the cart cleanliness was unchanged.
The LTCH Inspector #640 interviewed the Dietary Manager to review the expectations of cleaning the cart in the dining room on the resident units floor and they indicated to use this equipment to serve meals to residents was unacceptable due to the cracks and the debris. The Dietary Manager (DM) directed the dietary aides to cease using the equipment. The equipment was taken out of service.
The Dietary Manager confirmed that staff were expected to clean the equipment every Wednesday and the staff did not follow the policy and cleaning schedule. [s. 72. (7) (a)]

WN #11: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for, (a) cleaning of the home, including, (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Observation of one dining room on four specific dates in December 2016, identified that all dining table legs were found to be encrusted with debris, which was easily removed by the LTCH Inspector using paper towel and cold water. Resident dining chairs were found to be encrusted with debris and dried spills on the seat, arms, frame and chair legs. Observation of the cleaning of the dining room after lunch on two specific dates in December 2016, revealed there was no cleaning or wiping of the dining table legs or any part of resident dining chairs.
The Environmental Manager (EM) confirmed that it was expected that staff clean the table tops to include the sides and the underneath portion of the tables, and that spot cleaning as needed of spills and debris from table legs, chair legs and chair frames was expected to occur after each meal. After a review of the findings with the EM, the EM told the Inspector the dining table legs and resident dining chairs had not been regularly cleaned and in fact, were not clean.

The home did not ensure that procedures were implemented to ensure the resident furnishings and contact surfaces were clean. [s. 87. (2) (a) (ii)]

2. The licensee failed to ensure as part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee shall ensure that procedures were developed and implemented for, (d) addressing incidents of lingering offensive odours.

During Stage 1 observations of one of the resident units in December 2016, by LTCH Inspector #619 offensive odours were identified in two resident bathrooms. During observation on two specific dates in December 2016, by LTCH Inspector #640, there was lingering offensive odours on one of the resident units in the hallway. The home had a policy entitled "Odour Neutralizers – Housekeeping", policy # XII-G-10.30 and revised January 2015, which directed housekeeping staff to notify the Supervisor of any area which may require assessment for the use of odour neutralizing agents. The policy directed the Environmental Manager (EM) to 1) Determine areas which require odour neutralizing, 2) Liaise with Support Services Consultant to determine most effective products, 3) Order non-aerosol products only, 4) Provide education and training on the use of chosen product and 5) Ensure that the UV/air cleaning units were operating efficiently. The EM was aware of and confirmed the lingering odours on the specific resident unit. The EM had discussed with a third party what might be implemented to manage the lingering odours. The third party recommended some type of "tea" oil for the odour, but this was not implemented. The EM confirmed that it was expected of staff to notify the EM of an offensive odour and steps would be taken to identify and rectify such as using air freshener and/or a UV unit. Staff did not notify the EM and the UV unit was not implemented. The home did not ensure procedures were implemented for addressing the incidents of lingering offensive odours. [s. 87. (2) (d)]

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

Issued on this 24th day of January, 2017

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

Original report signed by the inspector.