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

Health System Accountability and Performance Division
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
Oct 17, 2014	2014_240506_0023	T-000057-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

KIPLING ACRES
2233 KIPLING AVENUE, ETOBICOKE, ON, M9W-4L3

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

LESLEY EDWARDS (506), JESSICA PALADINO (586), MARILYN TONE (167)

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): October 7, 8, 9,10, 15, 16 and 17, 2014

This inspection was conducted concurrently with Critical Incident Inspections T-675-13, T-261-14, T-557-14 and T-844-14 and Complaint Inspections T-264-13, T-599-13, T-610-13 and T-986-14.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Care (DOC), Nurse Managers, registered staff, personal support workers (PSW), dietary staff, recreation staff, Nutrition Manager, Counsellors, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed residents, reviewed resident health records, meeting minutes, policies and procedures, schedules, education records and complaint logs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

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. 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 did not ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.
i. On an identified date in October 2014, it was noted by Inspector # 586 that the Visitor's Pass swipe card provided to the inspectors to access areas of the home allowed access to the medication rooms on resident care areas.
ii. A review of all of the medication rooms at the home confirmed that on all units, the medication rooms could be accessed using the Visitor's Pass swipe card. It was noted that in at least three of the medication rooms, the medication carts were unlocked, and in all of the medication rooms, stock medications were accessible to anyone who entered the rooms. The narcotic bins in the medication carts were noted to be locked.
iii. During a discussion with the Assistant Administrator, it was confirmed that the swipe cards provided to the inspectors were also provided to contractors who work at the home. The Assistant Administrator was made aware that the visitor's pass allowed access to medication rooms and they indicated that they would notify their security department immediately to have the problem corrected. The Assistant Administrator confirmed that this was a programming error and that the cards should never have allowed access to the medication rooms. [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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs, and the Administrator, 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 did not ensure the home's policy related to managing and reporting complaints was complied with.

The home's policy "Managing and Reporting Complaints" (revised January 9, 2014) stated that all complaints need to be logged, regardless of whether they are verbal or in writing. Review of the home's Complaint Management Systems Log on an identified date in October 2014, revealed that the home's only documented complaints from 2013-2014 were from identified dates in January, 2013. Interview with the Administrator on an identified date in October 2014, revealed that they often receive verbal complaints that are dealt with immediately, however, also stated that these are not documented; therefore the home's policy was not being complied with. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was easily seen, accessed and could be used by residents, staff and visitors at all times.

On an identified date in October 2014, the bedroom call bell attached to the resident's bed in a room was not functioning when pushed and therefore could not be activated. Staff confirmed that the call bell was broken and could not be activated. The communication and response system was inaccessible to the residents in the room. [s. 17. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee did not ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

The following temperatures were observed:
i. On an identified date in October 2014, the thermostat in the spa room on the Akro home area indicated that the temperature was 20.5 degrees Celsius.
ii. On an identified date in October 2014, the thermostat in the spa room on the Pine Point home area indicated that the temperature was 20.8 degrees Celsius.
iii. On an identified date in October 2014, the thermostat in the spa room on the Akro home area indicated that the temperature was 20.3 degrees Celsius. [s. 21.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls for resident #100.

Review of resident #100's clinical health records revealed that a clinically appropriate assessment instrument was not completed when the resident experienced a fall on an identified date in July 2013, and again on an identified date in July 2013. The Acting Nurse Manager was unable to provide evidence that this was completed. Staff interviewed on an identified date in October 2014, confirmed that this form should be completed after every fall. [s. 49. (2)]

WN #6: 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 did not ensure that the advice of the Residents' Council or Family Council was sought out when developing and carrying out the annual satisfaction survey, and in acting on its results.

Interview with Residents' Council President on an identified date in October 2014, and interview with the Family Council President on an identified date in October 2014, revealed that the councils were not given the opportunity to participate in developing the home's satisfaction survey. This was confirmed by the Council Assistant and Manager of Resident Services on an identified date in Octobe 2014, and through review of the meeting minutes. [s. 85. (3)]

WN #7: 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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

From identified dates in October 2014, the wheelchairs of residents #001, #002 and #004 were observed to be dirty. Old food crumbs were noted on the seat of the chairs, and covering the bottom base in and around the wheels and handles. The registered staff confirmed that the wheelchairs were not kept clean and could not locate a cleaning schedule for staff to clean the wheelchairs. Interview with the Nurse Manager revealed that the units only have to pick four wheelchairs once weekly at the PSW's discretion to clean, and that there is no formal process in place to ensure that all residents get there wheelchairs cleaned. [s. 87. (2) (b)]

WN #8: 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 did not ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

The following were observed:
i. On an identified date in October 2014, several unlabelled used zinc oxide creams and white petroleum jelly, along with a used roll-on deoderant, were found on the shelf in the spa room on the Akro home area.
ii. On an identified date in October 2014, a used bar of soap was found on the shelf in the spa room on the Thistletown home area.
iii. On an identified date in October 2014, a used comb with hair in it, along with used unlabelled zinc oxide cream and petroleum jelly, were found in the spa room on the Humber home area.
iv. On an identified date in October 2014 two used combs with hair in them, a used petroleum jelly, and two used zinc oxide creams were found unlabelled in the spa rooms on the Pine Point home area. (586)
The registered staff confirmed that all personal items are to be labelled. [s. 229. (4)]

Issued on this 20th day of October, 2014

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