Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 31, 2017	2016_382596_0018	033566-16	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
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

THERESA BERDOE-YOUNG (596), JULIEANN HING (649)

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 2, 5, 7, 8, 9, 12, 13, 14, 15, 16, 2016.

The following Critical Incident inspection was conducted concurrently with this RQI: 033262-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator (AA), Director of Nursing (DON), manager of resident services (MRS), registered dietitian (RD), nutrition manager/production manager (NPM), manager building services (MBS), volunteer coordinator (VC), nurse manager (NM), acting nurse manager (A-NM), registered nurses (RN), registered practical nurses (RPN), practical care aides (PCA), physiotherapist (PT), counsellor, food service worker (FSW), laundry service worker (LSW), recreation service assistant (RSA), rehab assistant, support assistant (SA), hairdresser, Family Council President, Family Council member, Residents' Council leadership member, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, reviewed health records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

6 WN(s)
3 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. (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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During stage one of the Resident Quality Inspection (RQI), choices lacking related to lack of hairdressing service triggered for an identified resident.

Interview with the hairdresser revealed a record of the each resident's visit to the hairdresser was documented on a card, and signed by the unit nurse to confirm that resident's hair was done upon return to the unit. At the end of the month the card is sent to the office to process for payment.

Record review revealed an identified resident's hairdressing services contract signed on a specified date in May 2016, by the resident's power of attorney (POA) requested monthly hairdressing services.

Interview with the hairdresser on December 8, 2016, revealed that the last time he/she provided hairdressing service to the identified resident was in June 2016, and the resident's daughter paid cash. The hairdresser further stated that he/she did not have any record and could not recall providing hair service to the identified resident since June 2016.

On a specified date in December 2016, the inspector observed the identified resident getting his/her hair done by the hairdresser.
Interview with an identified support services staff revealed that there were no payments made from the resident comfort account for hairdressing services since his/her admission in May 2016.

Interview with the Assistant Administrator (AA) confirmed that it was the hairdresser's responsibility to ensure that the resident received the service, and it was an oversight on his/her part. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or the care set in the plan was no longer necessary.

During stage one of the RQI, skin and wound care related to an altered skin integrity concern triggered for an identified resident.

Record review of the resident’s most recent written plan of care under the section titled lack of skin integrity, did not indicate that the resident's care plan had been revised and updated after the resident developed impaired skin integrity in 2016.

Interviews with an identified registered nurse (RN) and nurse manager (NM) revealed that the identified resident’s written plan of care had not been updated to reflect the impaired skin integrity, and the RN stated that he/she had updated the written plan of care in December 2016.

Interview with the Director of Nursing (DON) confirmed that the identified resident‘s written plan of care should have been updated at the time of change in the resident's skin integrity. [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 that the care set out in the plan of care is provided to the resident as specified in the plan, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, or the care set in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Under O. Reg. 79/10, s.5 the definition of "neglect" in subsection 5 of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date, a critical incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an identified resident, who sustained a fall while being transferred from the bed to wheelchair by an identified practical care aide (PCA) who did not report the fall.

Interview with the identified resident revealed that he/she fell down while being transferred by an identified PCA. The PCA picked him/her up from the floor, assisted him/her onto a chair then took him/her to the dining room for lunch.

Interview with an identified registered practical nurse (RPN) revealed that the identified resident was trying to express something and looked different on the above mentioned day. Due to communication related issues, the RPN asked one of the food service workers (FSW) to speak with the resident. Subsequently the resident was interviewed by an identified counsellor and the Administrator, and reported that he/she fell while the above mentioned PCA was transferring him/her from the bed to chair. An investigation was started by the home and the PCA was removed from the unit.

A review of the home's investigation notes indicated that resident reported pain to an identified area of the body, identified medication was provided, and no other injuries were noted after a head to toe assessment was completed.

Interviews with the identified RPN, an RN, NM and AA confirmed that the identified PCA should have reported the fall and his/her actions of failure to report constituted actions of abuse and neglect towards the identified resident. [s. 19. (1)]

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 are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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 participated in the implementation of the infection prevention and control program.

During the RQI while conducting an observation of an identified resident's medication pass, the inspector observed that an identified RPN did not practice hand hygiene in between different routes of administration.

The RPN gave the identified resident three different routes of medications without performing any hand hygiene in between these activities.

Interview with the identified RPN revealed that he/she did not sanitize his/her hands in between the above mentioned activities and he/she told the inspector that he/she should have done so in between the different routes of medication administration.

Interview with the DON confirmed that the identified RPN should have cleaned his/her hands during the different routes of medication administration. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

A review of the home's policy titled medication management MM-0106-00, published 01-04-2016 under the narcotic and controlled medications section, titled documentation and monitoring, revealed following the administration of medication, staff should document in the medication administration record (MAR) and the combined monitored medication record with shift count.

On a specified date in December 2016, during the narcotic count on an identified unit with an identified RPN, the inspector observed that the combined monitored medication record with shift count record was not completely filled out for an identified resident. Further review of the record revealed that the medication was administered to the resident at a specified time in the morning, but at the time of the count at 1120 hours, the date, time given, administered by, and amount given were not completed on the home's combined medication record with shift count.

Interview with the identified RPN revealed that he/she had already given the identified resident his/her medication and had started to complete the combined monitored medication record with shift count with the count/balance amount, but had not completed the date, time given and by whom, and the amount given to the resident at the time of the narcotic count.

Interview with an identified RN revealed that once the medication was given to the resident the combined monitored medication record with the shift count should have been immediately completed.

Interview with the DON confirmed that the combined monitored medication record with shift count should have been completed at the time that the medication was administered to the resident. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI, skin and wound care related to a new skin integrity concern triggered for an identified resident.

Record review of the identified resident's treatment administration record (TAR) for a specified month in 2016 indicated impaired skin integrity. Further review of the TAR indicated that a weekly skin assessment was not completed on an identified date, as per the schedule on the TAR.

Interviews with an identified RN, NM and the DON confirmed that the identified resident should have had a weekly skin and wound assessment completed on the above mentioned identified date. [s. 50. (2) (b) (iv)]

WN #6: 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 has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

During the RQI while observing the narcotic counts on an identified unit, the inspector observed two ink refills for an e-pen stored in a plastic bag with a pink sheet of paper, in the narcotic drawer of the medication cart.

Interview with an identified RPN revealed that he/she did not know if the above mentioned items should be stored in the narcotic drawer of a medication cart.

Interview with an identified RN revealed that the above mentioned items should not be stored in the narcotic drawer of the medication cart, and immediately removed them.

Interview with the DON confirmed that the above mentioned items should not be stored in the narcotic drawer on the medication cart. [s. 129. (1) (a)]

Issued on this 13th day of February, 2017

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

Original report signed by the inspector.