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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 15, 2017	2017_370649_0001	000883-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Weston Terrace Care Community
2005 LAWRENCE AVENUE WEST TORONTO ON M9N 3V4

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

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

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 30, 2016, January 3, 4, 5, 6, 9, 11, and 12, 2017.

The following Complaint inspection was conducted concurrently with this RQI: 034544-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), resident assessment instrument (RAI) coordinator, environmental services manager (ESM), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), physiotherapist (PT), Family Council President, Residents' Council President, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, medication administration, 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
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

During stage one of the Resident Quality Inspection (RQI), minimizing of restraining triggered for an identified resident.

On a specified date in January 2017, resident was observed lying in bed with identified assistive devices engaged.

Record review of an identified resident's most recent plan of care revealed that there was no mention of the use of identified assistive devices.

Interview with Registered Practical Nurse (RPN) #105 revealed that the identified assistive devices should have been in the resident's written plan of care and stated the resident require the assistive devices for mobility.

Interview with the Director of Care (DOC) revealed that the identified resident's written

plan of care had been updated to reflect the use of identified assistive devices and then the intervention was discontinued on a specified date in November 2016. The DOC stated that a followed up should have been done and identified assistive devices should not have been discontinued or resolved in the written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During stage one of the RQI, an identified care area triggered for an identified resident.

Record review of an identified resident's most recent written plan of care revealed that an identified device was to be changed daily and as needed.

Interviews with Personal Support Worker (PSW) #126, RPN #101, Registered Nurse (RN) #125, and Assistant Director of Care (ADOC) #127 revealed the identified device is applied whenever the resident goes back to bed and a different device is applied whenever the resident gets up. ADOC and the RPN further stated that when the resident is up in the chair staff need to ensure the device is properly positioned.

Interviews with RPN #101, RN #125, and ADOC #127 revealed that an identified resident's most current written plan of care had not been updated to provide clear directions to staff and others who provided direct care to the resident.

Interview with DOC revealed that an identified resident's written plan of care had not been updated to reflect the staff practice. [s. 6. (1) (c)]

3. 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 RQI, minimizing of restraining triggered for an identified resident.

On a specified date in January 2017, at specified periods inspector observed an identified resident with two assistive devices engaged.

Record review of an identified resident's most recent written plan of care under an identified section revealed that the the resident required one assistive device.

Interview with PSW #100 revealed that the resident required one assistive device. PSW further stated that there is a picture above the resident’s bed to indicate the position of the identified assistive devices. The picture indicated that the identified one assistive device should be engaged.

Interview with RPN #101 revealed that the identified resident's assistive device should be engaged. RPN further stated that if the other assistive device was not mentioned in the resident‘s written plan of care then it should not be engaged.

Interview with the DOC revealed that the identified resident’s assistive devices should be the same as in the picture above the resident’s bed and the care plan should have been followed. [s. 6. (7)]

4. 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 change or care set out in the plan was no longer necessary.

During stage one of the RQI, continence care and bowel management triggered for an identified resident.

Record review of an identified resident's annual bladder and bowel continence assessment on an identified date in August, 2016, revealed that resident was incontinent and wore a brief.

On an identified date in January, 2017, at specified periods the inspector observed the resident wearing a brief.

Record review of an identified resident's most recent written care plan dated an identified date in November 2016, under an identified section reflected that the resident should wear an incontinent product different from a brief. Record review of the resident's kardex under an identified section reflected the use of a brief daily.

Interviews with PSWs #102 and #103 reported that the identified resident wore a brief as indicated on the kardex. PSW #103 stated that the resident used to wear an alternative product upon admission to the home in 2015, but didn't like it, so the incontinent product was changed to the brief more than six months ago.

Interview with RPN #104 confirmed that the resident's care plan should have been

updated to reflect that the resident is currently wearing.[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 there is a written plan of care for each resident that sets the planned care for the resident, that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, and 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 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. 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 staff participated in the implementation of the infection prevention and control program.

On an identified date in December 2016, during the initial tour of the home the inspector observed the following:

-sheets of transparent plastic bags secured with duct tape covering wall tiles in the shower area of the shower room on unit 2A. Through the plastic, mold and brown soap scum were visible on the tiles, in the grout between the tiles, and on the vinyl/linoleum strip under the tiles near the floor.

Interview with ADOC #114 revealed that he/she didn't know why the plastic was there. Interview with PSW #115 reported that he/she had observed the plastic covering the shower tiles since the previous Tuesday and the shower was still being used to shower residents.

Interview with the environmental service manager (ESM) revealed that the plastic sheets secured by duct tape were placed over the shower tiles to prevent water from seeping beneath them, the tiles were cracked as a result of residents wheelchairs constantly bumping into them. He/she reported that it had been that way for approximately one month, and agreed that the mold and brown soap scum was visible on the tiles under the plastic, in the grout between the tiles, and on the vinyl/linoleum strip under the tiles near the floor. The ESM reported that he/she had planned to repair the shower wall tiles in January 2017.

-used disposable razor on the shelf in shower room on unit 3B.

Interview with RPN #118 revealed that the used disposable razor should not be stored in the shower room, and it should be disposed of in the sharps container after use.

-unlabelled toenail clipper on the sink, two used disposable razors, one used deodorant stored on a shelf in shower room on unit 3A.

Interview with ADOC #108 revealed that the above mentioned items should not be stored in the shower room, they should be kept in residents' rooms and the toenail clipper should be stored in a cupboard in the medication room. The ADOC removed the items from the shower room immediately.

-unlabelled wash basin on the floor near the toilet, two used bars of soap and one used disposable razor stored in a shelf in the shower room on unit 4B.

Interview with RPN #119 stated that the bars of soap and wash basin should be stored in residents' rooms and the used razor should have been disposed of in the sharps container. [s. 229. (4)]

2. During the RQI, an identified resident approached inspector with a concern that staff do not clean and sanitize resident wash basins after each use, they are only rinsed with water before being stored in the washrooms.

Record review of the home's policy # VII-H-10.30 (a) titled Cleaning Schedule Nursing and Resident Care Equipment Cleaning Frequency directs PSW staff to clean basins by wiping off soil and cleansing with disinfectant after each use.

Interview with PSW #122 revealed that he/she rinses residents wash basins with soap and water day to day after each use. Uses virudex to santize them only if they are exposed to vomit or feces during resident care. PSW #122 stated that he/she did a.m. bed baths for three identified residents, used their wash basins and rinsed them out with soap and water after use, before storing them in the respective resident's washroom. He/she stated that there was no need to disinfect as there was no vomit or feces involved.

Interview with the DOC and ADOC #108 co-leads for the home's Infection Prevention and Control (IPAC) Committee revealed that the expectation is that PSWs wipe out residents wash basins with Accel wipes and disinfect with Virudex spray after each use, and before storing them in the residents' washrooms. [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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and has been conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During stage one of the RQI, continence care and bowel management triggered for an identified resident.

Record review of the resident's clinical record revealed that the resident was admitted to the home on an identified date in December 2015, and an admission bladder and bowel continence assessment was not completed for an identified resident. A continence assessment was completed ten months later on an identified date in October 2016.

Interviews with PSWs #111 and #106 revealed that the resident was incontinent of bladder at times.

Interviews with the continence care lead #107 and the ADOC #108 revealed that they were unable to locate an identified admission assessment for the identified resident, and it should have been completed when he/she was admitted to the home. [s. 51. (2) (a)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.