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

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2014	2014_369153_0012	T-059-14	Resident Quality Inspection

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - MUSKOKA
200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3

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

LYNN PARSONS (153), ANN HENDERSON (559), ARIEL JONES (566), BARBARA PARISOTTO (558)

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): September 25, 26, 29, 30, October 1, 2, 3, 6, 7, 8, 9, 10, 2014.

The following complaint log was inspected: T-485-13.
The following critical incident logs were inspected: T-430-14, T-631-14, T-654-14 and T-924-14.

During the course of the inspection, the inspector(s) spoke with the administrator, directors of care (DOC), assistant director of care (ADOC), director of dietary services (DDS), registered dietitian (RD), physiotherapist (PT), resident relations coordinator, programs manager, director of enviromental services (ESM), case manager, resident assessment instrument minimum data set (RAI MDS) coordinator, registered nurse (RN), registered practical nurse (RPN), personal support workers (PSW), maintenance staff, dietary aide (DA), ward clerk, dental hygienist, residents and families.

During the course of the inspection, the inspector(s) reviewed clinical health records, Resident and Family council minutes, air temperature records, dining servery report, RD communication tool, annual evaluations for relevant programs and relevant home policies and procedures;
completed observations of air temperatures, staff to resident and/or resident to resident interactions, provision of care, dining service, medication administration, medication storage area and conducted a tour in the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing
Training and Orientation

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 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every residents' right to be protected from abuse, is fully respected and promoted.

A record review revealed that residents #031 and #001, who are both cognitively impaired, were touched inappropriately by resident #026 on March 23 and April 30, 2014, respectively.

An identified PSW confirmed witnessing both incidents which occurred in common areas on an identified home area. Interviews with PSWs and registered staff confirmed that neither resident #031 nor resident #001 sustained any injuries or ill effects from the incidents. Staff interviews with registered staff and the DOC confirmed that resident #026 had been observed to inappropriately touch resident #031 in September 2013. The resident was moved to another unit in May 2014, as a result of these behaviours.

Interviews with the resident relations coordinator and DOC revealed that there were police investigations into the March 23 and April 30, 2014, incidents that did not result in any charges. An interview with the DOC confirmed that both resident #031 and resident #001's right to be protected from abuse was not respected and promoted. [s. 3. (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 every residents' right to be protected from abuse is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 written plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of resident #012's dining servery report identified the resident should receive no crusts. The resident was observed eating sliced bread with crust on October 1, 2014, at 12:12p.m. The written plan of care for resident #012 did not include this intervention.

Interviews with a dietary aide and a PSW revealed the staff were unaware of the no crust intervention and were providing bread/toast with crust to the resident.
An interview with the RD revealed the intervention, identified on the RD/FSM/nursing communication tool, was meant for the resident listed above resident #012's name and not resident #012. The DDS identified that the intervention on the communication tool appeared to belong to resident #012.

The RD and DDS failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Observations on October 2, 3, and 6, 2014, indicated that resident #006 has one half rail in the "up" position while in bed. An interview with the resident revealed that he/she uses one bed rail when moving around in bed. Interviews with PSWs and registered staff confirmed that the resident uses one half bed rail for bed mobility.

A review of the resident's care plan and kardex regarding bed mobility indicated that the resident is able to turn side to side while in bed, but fails to mention use of one half bed rail for turning and repositioning.

Observations on October 3, 6, and 7, 2014, indicated that resident #008 has one half rail in the "up" position while in bed. A review of the resident's care plan and kardex regarding bed mobility indicated that the resident requires assistance of one staff to reposition and turn in bed, but fails to mention use of one half bed rail for turning and repositioning.

Interviews with identified PSWs and registered staff revealed that the resident is able to hold onto the rail to assist with bed mobility.

An interview with the DOC confirmed that if a resident requires a bed rail for bed mobility that this should be outlined in the resident's written plan of care to ensure that all staff providing direct care are aware that a bed rail is used to help the resident reposition in bed. [s. 6. (1) (c)]

3. A review of resident #027's falls history indicated that the resident had several falls in May 2014, resulting in injury. Further review indicated that the resident has had multiple falls since May 2014, primarily at his/her bedside. Interviews with identified PSWs and registered staff indicated that many of the resident's falls were related to identified attention seeking behaviours that contribute to an increased falls risk. A review of the resident's care plan/kardex indicated that the resident has behaviour problems, but failed to identify his/her specific behaviours or that they contribute to a higher falls risk.

Interviews with the ADOC and DOC confirmed that the resident's care plan does not clearly identify behaviours that put him/her at a heightened risk for falls. [s. 6. (1) (c)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A review of resident #010’s dining servery report identified the resident should receive a regular textured diet and cut-up intervention of all foods. Observations made on October 2, 2014, at 12:19p.m. and 5:06p.m. revealed the resident cuts food independently.

Interviews with dietary and nursing staff on October 2 and 3, 2014, confirmed the resident cuts food independently. An interview with the RD revealed that the cut-up food intervention was implemented to address the resident’s chewing problems and risk of choking. The RD was unaware that the resident’s food was not being cut-up. The RD received a verbal referral and an email notification on October 6, 2014, related to the resident’s refusal of the cut-up intervention.

The dietary and nursing staff failed to collaborate with the RD in the assessment of the resident related to the cut-up intervention for chewing problems and risk of choking. [s. 6. (4) (a)]

5. A review of the post fall huddle for resident #009, indicated contributing environmental factors included a cluttered room, dim lighting and an assistive device that was in poor repair.

A review of the communication sent to Shopper's Home Health revealed "both brakes are broken, engage for short period of time and then drop off". Shopper's indicated the

home will provide another walker.

An interview with the PT indicated contributing environmental factors for the fall were due to the room being dark and many items in the room and not because the walker was in disrepair. The PT indicated the walker was at the end of its life span but remained safe.

An interview with the resident and an observation revealed the hand brakes on the walker did not stay engaged when applied.

The inspector raised the concern with the RPN who completed a follow-up and reported the walker had been removed from resident #009. The resident was provided the original walker that was used upon admission.

An interview with the DOC confirmed a lack of collaboration between staff and others involved in different aspects of care in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

6. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so the different aspects of care are integrated and are consistent with and complement each other.

A review of resident #011's dining servery report identified the resident should be offered chocolate milk. Observations made on October 1, 2014, at 12:21p.m. and October 2, 2014, at 12:30p.m. and 5:35p.m. revealed the resident had been served white milk.

An interview with a dietary aide stated the resident frequently refuses the chocolate milk and this was entered into a communication book. A record review failed to reveal any documentation related to the refusal of chocolate milk. An interview with the resident confirmed white milk is preferred.

An interview with the RD on October 6, 2014, revealed that the chocolate milk was identified as a fluid preference under the dehydration focus of the resident's care plan. The RD confirmed that she should be notified when the plan of care requires updating. An interview with the DDS on October 7, 2014, revealed she referred the frequent refusal of chocolate milk to the RD after becoming aware of the situation the

day before.

The staff failed to collaborate with the RD in the implementation of the resident's plan of care. [s. 6. (4) (b)]

7. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care.

A critical incident report related to an incident with injury involving resident #011 and resident #014, identified a referral was sent to Behaviour Support Ontario (BSO) for resident #014. A chart review did not locate the referral or subsequent assessment by the BSO team.

Interviews with the case manager and the charge nurse were unable to provide the referral document when requested by the inspector.

The staff failed to collaborate regarding the implementation of the referral to BSO. [s. 6. (4) (b)]

8. The licensee has failed to ensure that the substitute decision-maker (SDM) has been provided the opportunity to participate fully in the development and implementation of the plan of care.

A review of resident #001's progress notes identified a dietary referral was generated on August 28, 2014, related to a chewing and swallowing problem. On August 29, 2014, a temporary texture change was implemented by the DDS until the RD was available to assess. The RD assessed the resident on September 10, 2014.

An interview with the resident's SDM revealed and staff interviews confirmed that the SDM was not notified of the temporary texture change when it was implemented.

The DOC confirmed the SDM should have been notified of the problem and temporary intervention.

The SDM did not have the opportunity to participate fully in the development and implementation of the plan of care as it related to resident #001's diet texture. [s. 6. (5)]

9. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

A record review of resident #003's written plan of care revealed that the resident has a communication problem. Specific interventions were outlined within the care plan to enhance the resident's communication.

An interview with an identified PSW indicated that resident #003 has communication problems related to his/her diagnosis, but that there are no specific communication interventions used with this resident. Another identified PSW was unaware that there was a section for communication on the resident's kardex and reported that all staff have different ways of communicating with resident #003. Both PSWs stated that they do not review the resident's care plan kardex regularly.

An interview with an identified RPN confirmed that resident #003 has long-standing communication problems and that there are specific communication strategies outlined in the resident's written plan of care.

A record review of resident #006's written plan of care revealed that the resident has a communication problem related to his/her diagnosis. Specific interventions were outlined within the care plan to enhance the resident's communication.

An interview with an identified PSW indicated that resident #006 does not have communication problems and that he/she was unsure as to whether there were specific communication interventions used with this resident. Another identified PSW was unaware that there was a section for communication on the resident's kardex and reported that he/she just talks slowly to the resident. Both PSWs stated that they do not review the resident's care plan kardex regularly.

An interview with an identified RPN confirmed that resident #006 has communication problems and that there are specific communication strategies outlined in the resident's written plan of care.

An interview with the DOC confirmed that PSW staff are expected to review a resident's plan of care on a daily basis, whether they know the resident or not, before providing care to that resident. [s. 6. (8)]

10. Observations of resident #003's bed revealed one half rail in the "up" position on October 2, 3, and 6, 2014. A record review of the resident's written care plan revealed that the resident normally uses two half side rails while in bed for mobility and safety but is currently trialing one rail. The resident's most recent PASD/restraint assessment indicated that the purpose/function of the side rails are as a PASD.

Interviews with identified PSWs revealed that the resident is undergoing a trial of one bed rail and that staff are monitoring and recording use of one bed rail on an hourly basis on Point of Care. An interview with an identified member of the registered staff indicated that resident #003 uses two half side rails while in bed for mobility and safety, and that they are classified as a physical restraint. The identified registered staff member was unaware that the resident was undergoing a trial for one bed rail.

An interview with the DOC confirmed that the use of one half bed rail is not considered a restraint, and that if a resident was previously using two bed rails as a restraint and now using one half bed rail as a PASD, the registered staff should be aware of this change. [s. 6. (8)]

11. The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and at any other time when the resident's care needs changed or the care set out in the plan was no longer necessary.

A record review of the current written plan of care for resident #008 indicated that the resident is to be provided with a day plus yellow pad during the day and large beige brief during the evening and night (last updated May 26, 2014), and that the resident requires one staff assistance to use the toilet (last updated March 23, 2013).

Interviews with identified PSWs revealed that the resident requires a beige brief during all three shifts, and is either toileted using the mechanical lift or changed with the assistance of one to two staff in bed. Observations on October 7 and 8, 2014, confirmed that the resident wears a large beige brief during the day shift.

An interview with the ward clerk revealed that a verbal referral was made to change resident #008's day shift continence product from a yellow liner to a beige brief at the end of September, 2014.

A record review of the current written plan of care for resident #003 indicated that the resident wears a yellow liner (last updated June 20, 2013), and that the resident is

totally dependent on staff for toilet use and uses a specialized toileting sling during toileting care (last updated August 2, 2013).

Interviews with identified PSWs revealed that the resident requires a purple brief, and is generally incontinent or toileted using a bed pan. A PSW who had reportedly started working with resident #003 five months ago revealed that the resident had not been toileted using a lift and had worn a purple brief for the entire time. Observations on October 7 and 8, 2014, confirmed that the resident wears a medium purple brief during the day shift.

An interview with the ward clerk revealed that a written referral was received and a change was made on October 6, 2014, to update resident #003's continence product from a yellow liner during the day and evening shifts to a purple brief.

The DOC confirmed that resident's care plans should be updated both quarterly and when resident's care needs change. [s. 6. (10) (b)]

12. A record review of the current written plan for resident #027 indicated that the resident requires encouragement to have his/her walker with him/her at all times when up walking in both the dining room and bedroom (updated May 13, 2014).

Interviews with identified PSWs and registered staff revealed that the resident uses a wheelchair for mobility and has not been walking with his/her walker since an identified fall in May 2014, that resulted in an injury.
Observations on October 3, 7, 8, and 9, 2014, confirmed that the resident uses a wheelchair for mobility on the unit.

An interview with the ADOC confirmed that the resident uses a wheelchair for mobility, is on a walking program with physiotherapy, and that his/her care plan for falls was last updated in June 2014, related to a wheelchair alarm. The ADOC confirmed further that the resident's most recent fall was in August 2014, and that his/her care plan was not reviewed and revised at that time.

An interview with the DOC confirmed that a resident's care plan should be updated both quarterly and when a resident's care needs change. [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 written plan of care sets out clear directions to staff and others who provide direct care to the resident
- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident and in the development and implementation of the plan of care so the different aspects of care are integrated and are consistent with and complement each other
- the staff and others who provide direct care to a resident are kept aware of the contents of the plan of care
- each resident is reassessed, and the plan of care reviewed and revised at any other time when the resident's care needs change or the care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy and procedure titled Continence Management Program-Bladder and Bowel #V3-239, revised September 2013, indicates the following:
- registered staff will reassess continence status of the resident annually and with any change in resident condition that affects continence.

A review of resident #002's clinical health record revealed a continence assessment dated October 18, 2011. No additional continence assessments were available. An interview with the DOC confirmed that a continence assessment should have been completed for 2012 and 2013 for resident #002. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy and procedure titled Falls Prevention Program #V3-630 revised November 2013, indicated the following:
- the falls committee will review and analyze the falls that have occurred and look for trends.

An interview with the DOC confirmed the falls committee at present is not analyzing the falls in the home and completing a trend analysis. [s. 8. (1) (a),s. 8. (1) (b)]

3. The home's policy and procedure titled Medication Incident- Incident Reporting #V-960 revised April 2013, indicated the following:
Procedure:
- every registered nursing staff working in the home is responsible to identify and report a suspected or known medication incident to the nurse responsible for the nursing home at the time of the finding
- the nurse finding or reporting the incident initiates the medication incident report and submits the report as soon as possible to the nurse responsible for starting the investigation.

In April 2014, a report was received from a RPN that resident #039's medication patch was missing and this was the third time this had occurred. An investigation was initiated and measures implemented to monitor the medication patch for a period of time.

An interview with the DOC confirmed the previous two incidents whereby the medication patch was found not to be applied were not reported to the DOC and confirmed the home's policy and procedure had not been complied with. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to the following areas:
- continence care assessments
- falls prevention program
- reporting medication incidents, to be implemented voluntarily.

WN #4: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.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 the outside of the home are kept closed and locked.

On September 29, 2014, the inspector observed doors leading from first floor to the reception area that leads out of the building to be closed but not locked.

On September 30, 2014, a service request was sent to Aatel Communications to attend the site to repair the keypad operating the doors going onto the first floor. This keypad had been repaired prior to September 30, 2014, for the same issue. An interview with the ESM revealed the building security system is nearing its life expectancy and has been incorporated into the future capital budget for the home. Aatel Communications repaired the first floor doors on October 2, 2014.

On October 7, 2014, at 9:35a.m. the inspector observed the doors leading from first floor to the reception area to be propped open while touring with the ESM. There were colored signs posted directing individuals to ensure the doors were closed and access required a code.

The ESM closed the doors and confirmed they should not be propped open. [s. 9. (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 all doors leading to the outside of the home are kept closed and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home and furnishings are maintained in a safe condition and in a good state of repair.

On September 25, 2014, the following areas of disrepair were observed:
1 North
- outside room #141 - black marks on ceiling tile
- between room #139 & #140 storage room door - paint scraped at bottom of door
- across from med room - stains on ceiling tile
- activity room - counter top gouged, wood exposed and the trim was not affixed
- lounge - brown reclining chair, stuffing exposed on foot rest
- entrance to lounge - wall board chipped
- entrance between activity room and lounge - baseboard loose and falling off
- across from room #128 - wall board chipped in hallway

Tub room
- steel cover on floor paint scraped and rusted
- radiator cover - paint scraped and rusted

1 South
- activity room - wall board chipped and exposed
- entrance between activity room and lounge, significant wall damage near baseboard
- across from room #113 - wall damage in hallway

Shower room
- trim off the door with frame exposed
- radiator cover hanging off
- chipped ceramic wall tile near baseboard

2 North
- indent in wall outside the dining room in the hallway from door handles
- counter top in activity room gouged and trim missing with exposed wood
- entrance between activity room and lounge had wall damage above baseboard and some parts of the baseboard were missing and other parts hanging off

Tub room
- upper wall damage - holes in the wall board

Interim/Convalescent unit
- chipped counter top in the activity room at the end of the hall.

The ESM toured with the inspector and confirmed all identified areas required repair. [s. 15. (2) (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 to ensure the home and furnishings are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure a plan of care is based on, at a minimum, an interdisciplinary assessment of the resident's mood and behaviour patterns.

A review of resident #009's MDS assessment for August 2014, revealed coding errors in the mood and behaviour sections of MDS and the resident assessment protocol (RAP) summary as it relates to hoarding.

The MDS RAI Coordinator confirmed there were coding errors and that hoarding had not been identified and as such had not been care planned. [s. 26. (3) 5.]

2. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of safety risks.

A record review for resident #009 revealed a post fall huddle assessment in June 2014, that identified a cluttered room as a contributing factor for the fall. A second post fall huddle assessment in September 2014, identified contributing environmental factors to include cluttered room, dim lighting and an assistive device in poor repair. A review of the plan of care identified a fall prevention intervention to ensure the resident uses the walker at all times. The plan of care did not include fall prevention interventions to address the resident's behaviours or cluttered room.

An interview with the DOC confirmed the plan of care was not based on an interdisciplinary assessment of safety risks for resident #009. [s. 26. (3) 19.]

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 a plan of care is based on, at a minimum, an interdisciplinary assessment of the resident's mood and behaviour patterns, and safety risks, to be implemented voluntarily.

WN #7: 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 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.

A review of resident #003's MDS assessments and RAP summaries revealed that the resident had a history of urinary incontinence between January 2012, and July 2014. Further review of the resident's clinical assessments revealed that the continence/bowel assessment, the instrument used by the home to assess incontinence, had never been completed for this resident.

Staff interviews confirmed that resident #003 wears briefs for urinary incontinence and that there had not been a continence/bowel assessment completed for the resident since admission.

A review of resident #008's MDS assessments and RAP summaries revealed that the resident had a history of urinary incontinence between January 2013 and July 2014. Further review of the resident's clinical assessments revealed that the continence/bowel assessment, the instrument used by the home to assess incontinence, had not been completed since the resident's admission in January 2013.

Staff interviews confirmed that resident #008 wears briefs for bowel and bladder incontinence and that there had not been a continence/bowel assessment completed for the resident since admission.

An interview with the DOC confirmed that the continence/bowel assessment should be completed on admission and annually thereafter, and that both resident #003 and #008 should have received a continence/bowel assessment annually. [s. 51. (2) (a)]

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 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions.

A critical incident report was submitted to the Ministry involving a potentially harmful interaction between resident #013 and #014 in July 2014.
A record review of the incident revealed that two identified PSWs discovered resident #013 conscious and lying on the floor in resident #015's room, with blood visible around the resident's head. Resident #013 described the incident; resident #014 removed him/her from his/her wheelchair and threw him/her onto the floor. Resident #015 was present during the incident. The PSWs redirected resident #014 out of resident #015's room. Resident #013 was sent to hospital for further assessment and the police were notified and investigated the incident. The physician assessed the resident and added a new anti-psychotic to resident #014's medication regime. An interview with resident #013 on October 10, 2014, confirmed the incident had occurred.

A record review and staff interviews revealed that resident #014 has a history of physical aggression and is taking an anti-anxiety medication. There was previous involvement with the behavioural support team and the resident was discharged from the program in November 2013, as the resident was not exhibiting behaviours at that time. Record reviews and staff interviews revealed that resident #014 currently wanders and has acted physically aggressive at times, identifying that the resident is known to push, shove or choke residents or staff, if provoked.

During the record review an altercation involving resident #014 and another resident, #011, was identified to have occurred in August 2014. Resident #011 was found on the floor with a small laceration.

An interview with the DOC revealed that when a resident is identified with a behaviour, DOS charting and a referral to an external resource is completed. When asked for the DOS charting related to the incident in July 2014, the DOC was unable to produce the records. A record review and interview with the DOC did not identify a referral had been made to an external resource. [s. 54. (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 procedures and interventions are developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #9: 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 are stored in an area or a medication cart that is secure and locked.

On September 25, 2014, at 10:40a.m. the inspector observed the medication room door on an identified home area to be unlocked and to contain an unlocked medication cart.
Upon being notified of the unlocked medication room and medication cart the RPN locked both areas.

An interview with the DOC confirmed the medication room door and cart should have been locked. [s. 129. (1) (a)]

2. The licensee failed to ensure that controlled substances are stored in a separate locked area within the locked medication cart.

On September 25, 2014, at 10:40a.m. the inspector observed the medication room door on an identified home area to be unlocked and to contain an unlocked medication cart with an unlocked bin that contained controlled substances.
The inspector brought the situation to the RPN's attention who immediately proceeded to lock the medication cart and the medication room door.

An interview with the DOC confirmed that controlled substances are to be double locked. [s. 129. (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:
- drugs are stored in an area or a medication cart that is secure and locked
- controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: 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 all areas where drugs are stored are kept locked at all times, when not in use.

On September 25, 2014, at 10:40a.m. the inspector observed the medication room door on an identified home area to be unlocked where drugs are stored.
The RPN was notified and locked the medication room door.

An interview with the DOC confirmed the medication room door should be locked at all times when not in use. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there is a documented reassessment of each resident's drug regime at least quarterly.

Resident #041 was admitted to the home in April 2014. The first reassessment of resident #041's drug regime was scheduled to be completed for the period of July 1 to September 30, 2014. A review of the clinical health record on October 2, 2014, failed to locate a completed reassessment of the identified resident's drug regime.
An interview with the RN confirmed that a quarterly reassessment had not been completed since the resident had been admitted to the home. The RN planned to provide the quarterly reassessment of the drug regime to the physician on October 2, 2014, for review and authorization.

An interview with the DOC confirmed the quarterly reassessment of resident #041's drug regime had not been completed. [s. 134. (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 to ensure that there is a documented reassessment of each resident's drug regime at least quarterly, to be implemented voluntarily.

WN #12: 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 failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

The following air temperatures were observed in room #335:
October 2, 2014, at 10:25a.m. 17 degrees Celsius
October 3, 2014, at 1:30p.m. 17 degrees Celsius
October 6, 2014, at 1:50p.m. 17 degrees Celsius
October 7, 2014, at 9:40a.m. 18 degrees Celsius with the ESM
October 9, 2014, at 12:20p.m. 18 degrees Celsius with the maintenance staff.

The following temperature was observed in room #331:
October 9, 2014, at 12:25p.m. 20 degrees Celsius with the maintenance staff.

Interviews with ESM and the maintenance staff confirmed the air temperatures in the identified rooms were lower than 22 degrees Celsius. [s. 21.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed by the method of his or her choice.

On October 1, 2014, an interview with resident #012 revealed the resident prefers a shower and receives a bath. On October 3, 7 and 10, 2014, the resident confirmed preference for a shower.
A record review and staff interviews confirmed the resident is given a bath.

The DOC confirmed that residents should be offered a choice of bathing preference on an ongoing basis. [s. 33. (1)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A record review indicated that an identified concern directed to the environmental services department was raised during the July 7, 2014, Residents' Council meeting. A written response from the department head was provided to the Residents' Council assistant on July 24, 2014.

An interview with the Residents' Council assistant confirmed that a written response was not provided to this concern within the designated 10 day time frame. [s. 57. (2)]

WN #15: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home.

A review of the home's current process for determining satisfaction involves the use of the stage 1 questions from abaqis plus two additional questions regarding satisfaction using a scale from 1 to 10.

An interview with the administrator confirmed the current process completed within the home is an audit and does not determine satisfaction with services such as occupational therapy, physiotherapy, continence care and skin and wound program. [s. 85. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (3) The licensee shall keep a written record relating to each evaluation under subsection (2) 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. 216 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record related to the staff education program included the date of the evaluation, names of persons who participated in the evaluation and the date that the changes were implemented was completed.

An interview with the administrator confirmed the written record of the staff education program did not include the above noted items. [s. 216. (3)]

WN #17: 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 participate in the infection prevention and control program.

The following infection control concerns were observed on the following dates and times:
- one pair of unlabeled nail clippers in a general care caddy in the identified tub room on September 25, 2014, at 10:40a.m. and October 2, 2014, at 12:09p.m.
- yellow wander guard strips touching the floor outside rooms #124, #131 and #132 on September 25, 2014, at 10:25a.m.and October 2, 2014, at 12:14p.m.
- two unlabeled toothbrushes and an unlabeled black comb on the vanity of the shared bathroom in room #124 on September 25, 2014, at 10:50a.m. and October 2, 2014, at 12:12p.m.
- an unlabeled black comb and a toothbrush on the vanity of the shared bathroom in room #135 on September 29, 2014, at 2:35p.m. and October 1, 2014, at 3:02p.m.
- an unlabeled black pick comb on the vanity of the shared bathroom in room #223 on September 29, 2014, at 4:52p.m. and October 2, 2014, at 12:19p.m.
- an unlabeled hairbrush with strands of hair and an unclean, unlabeled electric razor in the identified tub room on October 2, 2014, at 12:23p.m.
- five unlabeled black combs in the identified shower room, two with strands of hair sitting in a denture cup in the care caddy on September 29, 2014, at 3:28p.m.
- two unlabeled black combs in the identified shower room, one sitting out on the sink with strands of hair in it observed on October 2, 2014 at 12:25p.m.

An interview with an identified PSW and registered staff revealed that wander guard strips should be stored back up on the door frames when not in use, that all resident's personal care equipment should be labeled, and any equipment used between residents should be disinfected in between use.

An interview with the DOC confirmed that as per the home's infection prevention and control (IPAC) practices, all personal care items in shared rooms and washrooms should be labeled to minimize the risk of cross-contamination, that anything touching the floor is an infection control risk, and all staff are expected to participate in the IPAC program. [s. 229. (4)]

Issued on this 7th day of November, 2014

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