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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## 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 |
|---|---|---|---|
| Jul 20, 2015 | 2015_377502_0008 | T-1926-15 | Complaint |

### Licensee/Titulaire de permis

ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES
59 Lawson Rd TORONTO ON M1C 2J1

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

TONY STACEY CENTRE FOR VETERANS' CARE
59 Lawson Road TORONTO ON M1C 2J1

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

JULIENNE NGONLOGA (502)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): March 26 and 27, 2015.**

**During the course of the inspection, the inspector(s) spoke with personal support workers (PSWs), registered nursing staff, housekeeper, environmental services manager (ESM), Resident Assessment Instrument (RAI) Coordinators, director of care (DOC), and residents.**

**The inspectors also conducted observations of staff and resident interactions, provision of care, record review of resident and home records, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Personal Support Services**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**s. 6. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

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

Interview with a family member of an identified resident indicated that an identified body part of the resident appeared to be infected.

Review of the care conference minutes indicated that an identified specialized care was to be provided. Record review of "PSW Documentation Records" for an identified period of time indicated that the resident's care did not occur on shower days during the above identified period of time.

Interview with an identified PSW indicated that he/she did not provide the care required because it needed to be provided by a specialist. Interview with an identified registered nursing staff confirmed that the resident had been referred to a specialist due to his/her

medical condition.

Interview with the DOC indicated that an identified resident's body part should have been taken care of on shower days. He/she revealed that the resident had not been referred to a specialist, because the resident's SDM declined services on admission. The DOC confirmed that the plan of care did not provide clear directions to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs.

Record review of the Resident Assessment Instrument (RAI)- Minimum Data Set (MDS) assessment on identified date, indicated that an identified resident required extensive assistance with one person physical assistance to use the toilet. The resident did not require care products.

On identified dates, the inspector noted lingering, offensive odours in the resident's bedroom.

Review of the most recent written plan of care revealed that the resident had an identified medical condition and was assigned an identified staff assistance.

Interview with identified staff confirmed that the resident urinates on the wall and vent within his/her bed room.

Interview with identified staff and the DOC revealed during an identified period of time, an identified staff was assigned to the resident for identified supervision.

Interview with an identified RAI-MDS coordinator indicated that the resident used to wake up during an identified period of time, he/she did not call for assistance and displayed identified behaviours. He/she confirmed that the resident plan of care did not reflect the need of the resident to receive assistance related to the above mentioned identified behaviours, during an identified period of time. [s. 6. (2)]

3. The licensee has failed to ensure that the plan of care for the resident covers all aspects of care, including recreational and social care.

Record review of the most recent written plan of care indicated that an identified resident had an identified medical condition. The resident was seen by a team of specialists, and

the following were recommended to help with his/her care:
- identify stressful times during the day for the resident, and schedule activities at other times,
- identify activities staff will provide outside.

A review of the written plan of care indicated and interview with an identified RAI-MDS coordinator confirmed that the identified resident activity patterns and pursuits were not included in the resident's plan of care. [s. 6. (3)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care documented.

A review of the most recent written plan of care indicated that an identified resident had an identified medical condition. A review of the progress notes revealed that the resident's medical condition resulted in him/her not receiving a specific care.

A review of the PSW documentation records revealed that the identified resident did not receive a specific care on fourteen occasions during an identified period of time.

Interview with an identified RAI-MDS coordinator indicated that in the past the resident's substitution decision maker (SDM) did visit regularly in the evening and assist with the identified care, but those visits had changed. When staff called the SDM for assistance with the above identified care, he/she indicated that could not for identified reasons.

Interviews with an identified PSW and the DOC confirmed that the identified resident did not receive care on the scheduled days identified in the written plan of care, but staff did not document when the identified care was provided on other days of the week. [s. 6. (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***
***- the plan of care set out clear directions to staff and others who provide direct care to the resident,***
***- the plan of care was based on an assessment of the resident and the resident's needs,***
***- the plan of care covers all aspects of care, including recreational and social care, and***
***-the provision of the care set out in the plan of care had been documented., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On an identified dates the inspector noted lingering and offensive odours in the rooms and washrooms of identified residents.

A review of the environmental department staff meeting minutes held on an identified date revealed and the ESM confirmed that the home had identified ongoing lingering odours in the above mentioned rooms. The following plan was implemented to address the odours:
- identify the source of the lingering offensive odours in resident's rooms,
- change job routine of housekeeping staff by increasing the cleaning and disinfection of the above identified rooms from one to three times per day,
- assign an extra housekeeping staff to check both rooms before the end of the shift,
- introduce a new chemical, Odour Counteract Neutralizer, and
- complete a deep cleaning in both rooms quarterly.

Interviews with identified staff revealed that the offensive odour is a result of the above identified residents behaviour. The housekeeping staff also indicated the above mentioned interventions that were implemented had not been effective, because the urine had infiltrated the floor tiles.

Interview with the ESM confirmed that the lingering offensive odours embedded in the floor tiles in the identified rooms persisted as a result of repeated exposure to urine, despite the process implemented. [s. 87. (2) (d)]

***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 are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

A review of the most recent written plan of care revealed that an identified resident had an identified medical condition. Review of the progress notes revealed that the resident's medical condition resulted in the resident not receiving identified care. A review of the MAR revealed that the resident had a drug regime that included scheduled and as needed (prn) medications that should be given prior to provision of the identified care.

A review of an identified specialist's report revealed that on an identified date, an identified resident exhibit an identified behaviour. The resident was transferred to the hospital for evaluation by an identified specialist and for a review of his/her medications. The identified specialist documented that "the resident did not receive his/her scheduled medications on an identified date".

A Review of the MAR for an identified period of time indicated that the resident did not receive his/her medications as follows:
- On identified dates the resident did receive scheduled medication, did not receive prn medication and staff did not provide him/her the identified care.
- On identified dates the resident did not receive scheduled and prn medications and staff did not provide him/her an identified care.

Interview with an identified staff confirmed that the above mentioned medications were not given to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #4: 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,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident who was incontinent of bladder had an individualized plan of care that promoted and managed bladder continence based on an assessment.

A review of the MDS assessment on an identified date revealed that an identified resident was frequently incontinent. A review of the most recent written plan of care revealed that strategies and interventions to manage the resident's incontinence were not included in the written plan of care.

Interview with an identified RAI-MDS coordinator confirmed that the resident was frequently incontinent, and was at high risk for falls during transfers. He/she indicated that staff should assist the resident with toileting after each meal. He/she confirmed that these interventions, to promote and manage the resident's continence were not care planned. [s. 51. (2) (b)]

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**Issued on this 26th day of August, 2015**

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

**Original report signed by the inspector.**