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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 21, 2013	2013_189120_0079	H-000703-13 30	Other

Licensee/Titulaire de permis

MISSISSAUGA LONG TERM CARE FACILITY INC.
26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7

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

MISSISSAUGA LONG TERM CARE FACILITY
26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7

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

BERNADETTE SUSNIK (120), ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 5 & 6, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Services Supervisor, recreation staff, registered staff, personal support workers (PSW), dietary staff, president of the Resident's Council Committee and residents.

During the course of the inspection, the inspector(s) toured the home, tested the staff-resident communication and response system, door alarms, lighting levels, hot water temperatures, observed meal service, reviewed health records, policies and procedures and Resident Council Committee meeting minutes.

The following Inspection Protocols were used during this inspection:
Dining Observation

Family Council

Residents' Council

Safe and Secure Home

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. 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).

Findings/Faits saillants :

1. Resident #00002, #00003, #00004 and #00005 did not receive care as specified in their plan related to bowel and bladder incontinence, requiring total assistance with toileting.

On November 5, 2013 at 1110 hours the identified residents were observed sitting in a dining room. All four residents were sitting in the dining room with their heads down and meal aprons around their neck. A Personal Support Worker (PSW) was interviewed who confirmed that the residents were brought to the dining room for breakfast between 0800 and 0815 hours and the breakfast was finished at 0915 hours. The PSW confirmed that the identified residents had been sitting in the dining room for over 3 hours after breakfast and were not toileted or checked for wetness. The plan of care for all four residents identified the requirement for total assistance with toileting related to bowel and bladder incontinence.

The active plan of care for Resident #0002's identified that staff were to toilet the resident every 2 hours (Q2 hours) or before and after the meal.

The plan of care for resident #00003 and resident #00004 identified under the Incontinent Program that staff were to check for wetness before and after the meals, before bed time and on rounds during night.

The plan of care for resident #00005 stated that staff were to ensure that the resident was dry and clean by toileting every 2 hours. The staff were to provide total care for all toileting procedure.

Interview with the PSW and observations made confirmed residents had been sitting in chairs for over three hours and were not checked for wetness and toileted. The care set out in the plan of care was not provided to the residents as specified in the plan. [s. 6(7)]

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 residents as specified in the plan, to be implemented voluntarily.

WN #2: 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; O. Reg. 363/11, s. 1 (1, 2).

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 has not ensured that all doors leading to stairways and to unenclosed outdoor areas of the home are kept closed and locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be canceled only at the point of activation.

The basement or ground floor has a resident dining room/activity room which residents use on a daily basis. The area can be accessed by an elevator or two stairwells, one on the north side and one on the south side. The stairwell doors leading up to the first floor from the ground floor are not equipped with a door access control system. [9(1)i,ii]

The north and south stairwell doors located on the 1st, 2nd and 3rd floors are equipped with a door access control system which are not equipped with an audible door alarm that allows calls to be caneled only at the point of activation and are not connected to the resident-staff communication and response system. The doors when left ajar did not alarm and the visual enunciator panel did not have the doors connected to the panel. [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 stairways and to unenclosed outdoor areas of the home are kept closed and locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be canceled only at the point of activation, to be implemented voluntarily.

WN #3: 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 did not respond in writing to the concerns that were raised by residents' Council within 10 days.

Review of Residents' Council meeting minutes, interview with the President of the Residents' Council, and the Management staff confirmed that the concerns, suggestions and recommendations regarding staff mannerism, food, menu changes, clothing labels, and equipment identified in the meeting minutes of February 2012, April 2012, June 2012, January 2013 and May 2013 were not responded to in writing within 10 days of receiving advice from the Resident's Council. [s. 57(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 the licensee responds to the concerns or recommendations in writing within 10 days of receiving advice by the Resident's Council, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents remained at or below 49C.

Water temperatures were taken at 10:30 a.m. and between 2 and 2:30 p.m. from resident accessible areas on the north side of the building. The water was recorded to be 54C on the 1st floor and 53C on the 2nd floor at both times. Water temperature logs were reviewed and no hot water temperatures over 49C was recorded between January and November 6, 2013 in resident accessible areas. The source water temperatures were also recorded to be below 49C.

It was discovered that 3 domestic boilers supply hot water to resident areas. One boiler was equipped with a device that regulates the temperature and supplies hot water to certain sections of the building. No thermometer was noted on the system at the boiler. The other two boilers did not have a water regulation device connected to them. The two boilers were interconnected to supply hot water to the north side of the building and possibly other sections of the building. The one boiler was reported by a maintenance person to have been set at 122F or 50C. However, an accurate temperature of the water supply leaving the boilers could not be acquired, as an in-line thermometer was not available. A probe thermometer was connected to the outside of a hot water line which was not adequately measuring the hot water temperature inside the line. Staff were using this probe thermometer temperature to record the hot water source temperature in the water log.

The hot water was not being monitored adequately to ensure that hot water from all sources was being tested once per shift in resident accessible areas. The water temperature log set out locations for staff to test the water that only identified water being supplied by the one tank on certain dates. [s. 90. (2) (g)]

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 implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents remains at or below 49C, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents was restricted to an opening of no greater than 15 centimeters.

Over 20 windows located in common areas and resident rooms were observed to be missing a mechanism to restrict the window from opening more than 15 centimeters. When an inquiry was made, staff reported that air conditioners were removed in October and the mechanisms were not re-installed. The licensee directed the maintenance person to re-install the mechanisms once it was brought to their attention. [s. 16]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The resident-staff communication and response system was not available in every area accessible by residents. Activation stations were not provided in the ground floor dining area, 1st floor dining area or the 2nd floor lounge room (formerly a dining area). [s. 17(1)(e)]

2. The resident-staff communication and response system uses sound to alert staff when an activation station is pulled or activated. The system was tested and was found to be properly calibrated so that the level of sound was audible to staff. However, the system, which is required to have stairwell and perimeter doors connected to it, does not sound when a door does not close properly.,

The ennunciator panel which was observed to have 4 perimeter doors connected to it, sounded only at the panel and not throughout the corridor. Staff working in resident rooms, washrooms or down a corridor would not be able to hear the sound. The sound was also noted to be off at the time of the inspection and had to be switched on to complete the test. [s. 17(1)(g)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The lighting requirements set out in the lighting table have not been maintained.

Only the 1st and 2nd floors lighting fixtures were measured, other areas were not tested, but had similar lighting fixtures in style and number. A lighting assessment of the whole home by a lighting consultant would be required to determine other areas of non-compliance.

Corridors on the 1st and 2nd floor were measured using a light meter, held 4 feet above the level of the floor. The corridor lights were double strip 4 foot fluorescent tubes with opaque lens covers. Corridor lights ranged in illumination levels between 100 and 350 lux. Levels between the fixtures were measured to be between zero and 50 lux, depending on the span between fixtures. None of the corridors had a consistent continuous lux of 215.28.

Resident rooms on 1st and 2nd floor each had one flush mounted fixture with an antique bronze glass cover and fluorescent bulbs centrally located in the room. These were measured and gave off 80 lux of illumination. A minimum level of 215.28 lux is required.

Common washrooms on the 1st floor had square shaped flush mounted fixtures with fluorescent bulbs that were measured and provided a lux of 175-190. Common washrooms on the 2nd floor had a variety of lighting fixtures. Common washroom #2 - 200 lux, washroom #1 - 110 lux, resident washroom in #209 - 50 lux. A minimum level of 215.28 is required. [s. 18.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 58. Residents' Council assistant

Specifically failed to comply with the following:

s. 58. (2) In carrying out his or her duties, a Residents' Council assistant shall take instructions from the Residents' Council, ensure confidentiality where requested and report to the Residents' Council. 2007, c. 8, s. 58. (2).

Findings/Faits saillants :

1. The licensee did not ensure that the Resident's Council assistant took all instructions from the Residents' Council in carrying out his or her duties.

On November 5, 2013, interview with the President of the Residents' Council confirmed that the Residents' Council had raised ongoing concerns regarding fluctuating water temperatures when showers were being provided to residents. The assistant did not record this concern in the minutes but recorded other concerns that were raised at the same time. During the inspection, the assistant confirmed that few months ago the water temperature issue was raised by the members of the Residents' Council and they did not record the concern but instead verbally informed the licensee/administrator. The meeting minutes did not capture all concerns/issues raised by the residents, the Residents' Council assistant did not take instruction from the Residents' Council. [s. 58(2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. On November 5, 2013 residents were not offered all planned menu items at lunch. The planned menu posted indicated whole wheat buttered bread is offered every day at lunch and dinner, however, residents were not offered bread at lunch. The dietary staff confirmed that the bread was on the menu but was not sent from the kitchen. Residents interviewed confirmed bread was offered some time at lunch but not every day. [s. 71(4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Resident #00001 was not provided with an assistive device required to safely eat and drink as comfortably and independently as possible. The dietary profile available for staff reference and the plan of care both indicated that the resident was to be provided an adaptive device for all beverages. However, on November 5, 2013 during lunch the identified resident was served beverages in regular plastic drinking glasses. The resident was observed to be experiencing difficulty drinking their beverage out of the regular glass. [s. 73(1)9]

2. Proper feeding techniques were not used to assist a resident at the lunch meal on November 5, 2013. During the first floor lunch meal service staff were observed standing to feed a resident instead of being at eye level when assisting the resident. [s. 73(1)10]

Issued on this 26th day of November, 2013

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

B. Susnik   Asha Sehgal