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

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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
May 16, 2014	2014_362138_0003	O-000310-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road, OTTAWA, ON, K1G-5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6

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

PAULA MACDONALD (138), ANANDRAJ NATARAJAN (573), JESSICA LAPENSEE (133), LISA KLUKE (547), RUZICA SUBOTIC-HOWELL (548)

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): May 5, 6, 7, 8, 9 and May 12, 13, 14, and 15, 2014

The following inspections were also completed as part of the RQI:
O-001046-13 Complaint Inspection
O-000214-14 Critical Incident Inspection
O-000220-14 Critical Incident Inspection

During the course of the inspection, the inspector(s) spoke with residents and family members, resident companions, a past President of the Residents' Council, the President of the Family and Friends Council, the Chief Executive Officer, the Executive Assistant, the Chief of Resident Care, the Director of Nursing Practice, the Director of Resident Care, the Manager of Nursing Education and Support Services, the Continuous Quality Improvement Associate, a RAI Coordinator, a PSW Supervisor, a Geriatric Psych Nurse (ROH), the Infection Control Coordinator, a Recreation Therapist, two Food Service Supervisors, the Manager of Support Services, the Supervisor of Property Services, a Physiotherapist, a Physiotherapy Assistant, the Pharmacy Manager, a Pharmacist, a Regulated Technician (Pharmacy), several Registered Nurses (RN's), a Behaviour Support Ontario (BSO) worker, the Coordinator for Volunteer Services, several Registered Practical Nurses (RPN's), several Personal Support Workers (PSW's), Several Food Service Workers, and a Housekeeping Aide.

During the course of the inspection, the inspector(s) reviewed two Critical Incident Reports, reviewed residents' health care records, reviewed some of the home's policies and procedures, toured resident rooms, toured resident common and non common areas, reviewed the admission package, reviewed Resident Council and Family and Friend Council minutes, reviewed pest control documentation, reviewed written housekeeping routines, verified the function of the home's communication response system (call bell system) observed medication passes, observed several lunch meal services, observed staff to resident interactions, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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. 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 has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 15 (2) (a)

in that the licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary. This is specifically related to the dining room chairs in identified areas, folding fabric dividing walls in dining rooms in identified areas, wall surfaces in dining rooms in identified areas, and wall surfaces in a resident lounge in an identified area. The following presents a pattern of non-compliance.

a) A resident expressed concerns related to the cleanliness of dining room chairs in the Ottawa 2 West (O2W) dining room, to Long Term Care Home (LTCH) Inspector #138 on May 6, 2014, during the Resident Quality Inspection (RQI) stage 1 resident interview activity. On May 9, 2014, LTCH Inspector #133 went to the O2W dining room and observed that not all dining room chairs are being kept clean and sanitary. Six blue chairs observed were stained and dirty with dried matter, typically of a light colour. This was seen on the inner and outer area of the back rest and well as in the seat area.

b) LTCH Inspector #133 made the following observations, in the identified areas, on May 14, 2014:

Gatineau 2 South - back of unit dining room:

The folding fabric diving wall that separates the dining space from the storage space is heavily soiled with dried matter and stains of various colours.

The lower walls at the front of the room are dirty with dried matter of various colours.

Gatineau 2 North – front of unit dining room:

The lower walls around the perimeter of the room are dirty with dried matter of various colours, as is the outer surface of the heat radiator.

Gatineau 2 North East – resident lounge:

The lower window frame area, next to the brown chair, is dirty with dried pink matter.

The lower wall next to the other brown leather chair, upon entry to the lounge, is dirty with dried green and dark coloured matter. The lower wall and baseboard around the corner from this chair, within the hallway, are dirty with dried matter.

Gatineau 2 North East – back of unit dining room:

Dining room chairs are not being kept clean and sanitary. Nine of the observed chairs are stained and dirty with dried food matter, primarily in the front and centre of the seat area, but also noted on the inner and outer face of the back rest.

The base of four of the dining room tables was noted to be dirty with dried food matter.

The folding fabric diving wall that separates the dining space from the storage space is heavily soiled with dried matter and stains of various colours.

Gatineau 1 South – front of unit dining room:

The wall next to the sink is heavily soiled with dried matter of various colours.

The wall next to the piano, leading around to the servery is also soiled with dried matter of various colours.

As highlighted by a staff person working in the area, one of the vents above a table, in front of the servery, is dirty with accumulated dust.

Gatineau 1 South – back of unit dining room:

Dining room chairs are not being kept clean and sanitary. Five of the observed chairs were stained and dirty with dried matter.

The folding fabric dividing wall that separates the dining space from the storage space is heavily soiled with dried matter and stains of various colours. [s. 15. (2) (a)]

2. The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, s. 15 (2) (c) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. This is primarily related to the condition of wall surfaces in identified common areas as well as in three resident bedrooms. The condition of flooring in three identified common areas is in issue, as is a the pull station for the resident-staff communication and response system (call bell system) in an identified tub room.

a) LTCH Inspector #133 made the following observations in the identified areas on May 14, 2014:

Gatineau 2 South East - tub room:

As was initially observed by LTCH Inspector #547 on May 7, 2014 during stage 1 of the RQI, the tub room walls were in poor repair. Behind the tub, there is a large area where the green paint has cracked and is peeling away from the wall. As well, on the wall next to the toilet, there are several areas, of varying sizes, where the paint is lifting away from or has completely come off of the wall and the drywall beneath is exposed. The exposed drywall is cracked within two of the smaller affected areas, just above the baseboard. These areas can no longer be effectively cleaned and disinfected as a result.

Gatineau 2 South - back of unit dining room:

The post between the two folding fabric diving walls has been heavily damaged, paint and drywall have broken away from the corners, exposing the metal strapping beneath. This area can no longer be effectively cleaned and disinfected as a result. The lower wall at the front of the room, from the entrance towards the servery, is in poor repair. Paint has been scraped away and the drywall beneath is exposed, and is gouged in areas. These areas can no longer be effectively cleaned and disinfected as a result.

One of the blue fabric dining room chairs has been torn, along the right side of the seat area. The inner foam padding is exposed.

Gatineau 2 South East – bedroom #281:

The wooden mid wall ledge, that runs parallel to the bed, is in poor repair. The protective surface has been damaged, exposing the raw wood beneath, which has chipped and splintered along the top. The most significantly affected area is next to the head of the bed.

Gatineau 2 South West – tub room:

Walls are in poor repair. On the wall behind the toilet, to the left and the right, paint has lifted and is peeling away from the wall. The wall next to the toilet has been

scraped and gouged, exposing the drywall. These areas can no longer be effectively cleaned and disinfected as a result.

Gatineau 2 South West – shower room:

The corner of the wall in front of the shower area is in poor repair. Paint and drywall have broken away, exposing the metal strapping beneath. This area can no longer be effectively cleaned and disinfected as a result.

Entrance to the Gatineau 2 South West unit, rooms #276-299:
As was initially observed by LTCH Inspector #573 on May 7, 2014 during stage 1 of the RQI, the lower wall is in poor repair. There is a hole in the lower wall that measures approximately 23cm x 19cm.

Gatineau 2 North East – shower room:

The wall in front of the shower area is in poor repair. Paint and drywall have been chipped away in two distinct areas, exposing the metal strapping beneath. This area can no longer be effectively cleaned and disinfected as a result.

Gatineau 1 South West – bedroom #181:
As was initially observed by LTCH Inspector #548 on May 6, 2014, during stage 1 of the RQI, the wooden mid wall ledge, that runs parallel to the bed, is in poor repair. The protective surface has been damaged, exposing the raw wood beneath, which has chipped and splintered along the top. As well, the lower wall area beneath this ledge, at the head of the bed, has been extensively gouged.

Gatineau 1 South West – tub room:

The wall next to the toilet is in poor repair. There is a hole in the wall, next to the toilet. Paint has been chipped away from areas next to the paper towel dispenser, exposing drywall beneath, which is cracked. This area can no longer be effectively cleaned and disinfected as a result.

Gatineau 1 South – front of unit dining room:

The wall next to the sink is deeply gouged throughout and there is a hole in the lower center area.

Gatineau 1 South East - tub room:

Paint is peeling and lifting away from the wall around the sink. This area can no longer be effectively cleaned and disinfected as a result.

Gatineau 1 South East - shower room:

The wall space beneath the shower bench has been covered up by clear plastic, affixed with duct tape, as lower tiles are missing/have been removed. The lower wall to the right and left of this area is cracked and peeling, exposing the drywall beneath. This area can no longer be effectively cleaned and disinfected as a result. A personal support worker in the area, Staff #129, told the inspector that the wall area has been in this state "for the last few months, since January or February, at the latest".

Gatineau 1 South – back of unit dining room:

The post between the two folding fabric diving walls has been heavily damaged, much of the drywall has broken away from the corners, exposing the metal strapping beneath. This area can no longer be effectively cleaned and disinfected as a result.

Ottawa 1 West – bedroom #192

As was initially observed by LTCH Inspector #547, on May 6, 2014, during stage 1 of the RQI, the wall beneath the resident's sink is in poor repair. The wall area is extensively scraped and is deeply gouged in two distinct areas. This area can no longer be effectively cleaned and disinfected as a result.

b) As was initially observed by LTCH Inspector #547, on May 5, 2014, during stage 1 of the RQI, flooring is in poor repair in three common areas. Details are as follows:

On May 9, 2014, LTCH Inspector #133 observed a long crack in the floor tiles at the entrance to the Rideau 2 link. The cracked area measures a total length of approximately 117cm, and 1 – 2.5 cm in width. On May 14, 2014, the Supervisor of Property Services explained that this crack is over an expansion joint, and that the grouting used to affix the tiles over the joint has likely dried out, allowing the tiles to release and crack along the joint.

On May 9, 2014, LTCH Inspector #133, observed a long crack in the floor in the Ottawa 1 link corridor, near the base of the stairs. The crack measures a total of 130cm in length, and 1.5cm in width, with the exception of the end closest to the pillar, where a piece of the floor tile has broken off. This specific area measures 31cm x 5.5cm, with a depth of approximately 0.4cm, resulting in an uneven surface that could present as a tripping hazard. This was discussed with the Supervisor of Property Services on May 14th, 2014 and the area was repaired by days end. The Supervisor of Property Services explained to the inspector that this is a result of a slight separation of the concrete slab in the area, as opposed to an expansion joint.

On May 9, 2014, LTCH Inspector #133 observed, in Lupton Hall, an area of damaged flooring in front of the third set of doors. The predominantly affected area measures approximately 190cm x 150cm. One area of flooring is lifted up 0.6cm, and the outer edges of flooring finish on other sections is lifting and peeling, resulting in an uneven surface that could present as a tripping hazard. Heavily worn duct tape is in place over some sections. This was discussed with the Supervisor of Property Services on May 14, 2014 who informed that the floor damage was sustained in the fall of 2013, and is a result of water accumulating in the area, that came in from under the door sill. The Supervisor of Property Services informed that the floor in Lupton Hall will be replaced in June.

c) Gatineau 2 South West – tub room

The resident-staff communication and response system (the call bell system) pull station was initially noted not to be working as required on May 7, 2014, during Stage 1 of the RQI by LTCH Inspector #547. On that day, LTCH Inspector #547 attempted to produce a call by pulling the system cord, and found that no call was produced. LTCH Inspector #547 was able to produce a call by depressing the switch on the system wall console. The cord is in place to allow staff to make a call for assistance while providing care to a resident, without having to stop the care and go to the wall. On May 14, 2014, LTCH Inspector #548 revisited the tub room and found that this malfunction persisted. LTCH Inspector #548 informed Staff #134, who indicated that they would report this to the maintenance department. [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 with the requirement that the home is maintained in a safe condition and in a good state of repair, specifically related to wall surfaces, flooring and a resident-staff communication and response system pull station, in identified areas, to be implemented voluntarily.

WN #2: 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 Licensee has failed to comply with O. Reg 79/10 s.17 (1) (a) in that the licensee did not ensure that the home is equipped with a resident-staff communication and response system that can be easily accessed and used by residents, staff and visitors at all times.

The home is equipped with a resident-staff communication and response system (commonly known as the call bell system) that clearly indicates through sound and lights when activated. This communication and response system is activated when a

resident, staff or visitor pulls on a call bell pull cord located in any resident accessible area including a resident's room or in the resident's washroom.

During the resident observation activity conducted at stage 1 of the RQI, it was noted by LTCH Inspectors #138, #547, #548, and #573 that there were residents who did not have access to their call bell pull cords or that the call bell pull cords were inaccessible. In other words, these inspectors observed that call bells were misplaced. Call bell misplacement was triggered for further inspection in stage 2 of the RQI.

LTCH Inspector #548, who was assigned to further inspect call bell misplacement, proceeded to Ottawa 1 West on May 12, 2104 and conducted a random audit of 49 resident bathrooms. Rooms 150 to 199 were audited for a total of 49 call bells pull cords. It was observed by LTCH Inspector #548 that 36.7 % (18/49) of the call bells pull cords were misplaced in the resident's own bathroom.

Of the call bells pull cords audited, 10/49 were wrapped around the towel bar, 5/49 were wrapped around the support arm beside the toilet, 2/49 were found to be laying behind a soiled utility cart then wrapped around the support arm and one call bell pull cord was left hanging from the wall. Those call bell pull cords that were wrapped around the towel bar were not within reach of a resident who would be using the toilet however, the call bells did activate when the LTCH Inspector #548 pulled the call bell pull cord. To see if the call bells would activate for those call bells (5/49) wrapped around the support arm beside the toilet the LTCH Inspector #548 pulled the call bell pull cords. Two of the call bells had to be forcibly pulled to activate the staff-resident communication system.

On May 12, 2014 LTCH Inspector #548 asked a staff member working on Ottawa 1 West to accompany LTCH Inspector #548 to rooms 150-176. The staff member identified a room for a resident on the unit who is known to use the call bell and it was observed at the time of the audit that the call bell pull cord was wrapped around the towel bar. The staff member indicated that the call bell pull cord was not accessible to the resident as the resident would not be able to reach the call bell pull cord. The staff member indicated that the expectation was for staff to always have the call bell pull cord unwrapped and laying over the support arm beside the toilet.

On May 12, 2014 during the audit of the resident call bells LTCH Inspector #548 and the staff member entered a resident room on the unit and observed the resident was

being toileted and that call bell pull cord to be wrapped around the towel bar. The staff member indicated that the resident used the call bell and immediately unwrapped call bell pull cord from the towel bar and placed it by the resident. The staff member indicated that the call bell pull cord was problematic as it is heavy and difficult to lie on top of the support arm and that the call bell pull cord slipped off the support bar therefore making it inaccessible to the residents.

On May 12, 2014 LTCH Inspector #548 asked another staff member working on Ottawa 1 West to accompany LTCH Inspector #548 to rooms 177-199. The staff member observed the toilet call bell system with the inspector for these rooms. The staff member indicated that only one resident uses the call bell system on the unit, and identified the resident's room to the inspector. It was observed by LTCH Inspector #548 that the call bell cord in the identified room was wrapped around the towel bar. During the audit, the staff member unwrapped the call bell cord from the towel bar and placed it on the support arm by the toilet. The staff member verified that the expectation at the home is to lay the call bell cord over the support arm beside the toilet and staff member indicated that s/he will inform the evening and night staff about how the call bell pull cord should be placed by the toilet in each resident's room from now on.

Additionally, it was also observed on May 14, 2014 in the tubroom in the West sub unit on Gatineau 2 South that the call bell pull cord was wrapped around a handrail and could not be pulled to activate the call bell. [s. 17. (1) (a)]

2. The Licensee has failed to comply with O. Reg. 79/10, s. 17 (1) (a) in that the licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (the call bell system) that is on at all times. This is specifically related to the Gatineau 1 South unit, including both the East and West sub units.

At approximately 4:30pm on May 13, 2014, in the Gatineau 1 South (G1S) front of unit dining room, a resident indicated to LTCH Inspector #133 that the "emergency button" in his/her bedroom was not functional and s/he was unable to call for help. When asked by the inspector how long the emergency button had not been working, the resident repeated "today". The resident did not clarify more precisely at what point on that day s/he noted the malfunction. The inspector proceeded to the resident's bedroom, and found that the call bell activation button on the bedside cord did not produce a call when pressed, or when the cord was pulled out of the wall console. As

well, the call bell pull cord at the toilet did not produce a call when pulled. The inspector informed a staff member in the area and the system was tested in other bedrooms. It was determined that the system was not functional throughout the entire Gatineau 1 South unit, which is comprised of the East and West sub units. The Supervisor of Property Services was called, and by 4:54pm the system was operable again following a system reboot performed by the Supervisor of Property Services on the care unit. The Supervisor of Property Services informed that the licensee intends to replace the system throughout the home and that the process of exploring which system to go with is actively underway.

A different staff member informed the inspector that staff had not responded to any system calls since the start of their evening shift, 3pm. The staff member explained that this was not surprising because there are only two residents within the G1SW sub unit that make calls with the system, one of whom is previously mentioned, and neither had been in their bedrooms as of the start of the evening shift. This indicates that the resident mentioned above would have become aware that his/her "emergency button" was not working in his/her bedroom prior to 3pm.

The inspector went over to the G1SE sub unit and met the two staff members working in the evening. Both evening staff members informed the inspector that they had not heard any calls from the system since the start of their evening shift, 3pm, and that this was not typical, because normally they would have some calls to respond to.

On May 14, 2014, the inspector spoke with a staff member on the G1SE sub unit, who had worked on the unit the day the system was not functional. The staff member informed the inspector that s/he remembered that a call had been made from a resident lounge within the G1SW sub unit, at approximately 2pm. The staff member said that s/he had seen this call reflected on the system console on the G1SE sub unit nurse station desk. The staff member said that s/he could not recall hearing another call after that time.

The resident-staff communication and response system (the call bell system) was not on and available for resident's use, throughout the G1S unit, during the later afternoon of May 13, 2014. [s. 17. (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 with the requirement that the resident-staff communication and response system is on at all times and is available to all residents, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8 , s. 6(1)(c) in that the plan of care does not set out clear directions to staff and others who provide direct care to the residents.

Upon review of the plan of care for a resident on May 9, 2014, LTCH Inspector #547 noted that the current care plan indicated the resident required a catheter to be changed every 3 months with a specific date outlined. The TAR (Treatment Administration Record) indicated a different change date.

LTCH Inspector #547 interviewed a staff member regarding the resident's catheter, indicating that the plan of care related to changing of the resident's indwelling catheter is based on the physicians orders. The physician's orders indicate indwelling catheter to be changed every 3 months and PRN. The staff member reviewed the TAR and most recent care plan for the resident which indicated different dates.

Following the discussion with the staff member, LTCH Inspector #547 verified within the resident's progress notes that the catheter was changed on a day different than

indicated in the TAR and in the care plan.

LTCH Inspector #547 interviewed the home's Director of Resident Care who indicated that the home's expectation regarding registered nursing staff changing resident's catheter would be reflected in the resident's TAR for the next date it would be due according to the physicians orders. [s. 6. (1) (c)]

2. A resident was admitted to the home in 2012 and has multiple diagnosis contributing to pain and potential weakness.

LTCH Inspector #573 reviewed the resident's recent plan of care and the last two physiotherapy quarterly assessments. The resident's plan of care identifies that the resident is in physiotherapy treatment for pain management, range of motion, strength, ambulation and balance exercises but both the plan of care and the physiotherapy quarterly assessment records do not identify the frequency of the physiotherapy treatments that is to be provided to resident.

Physiotherapist assistant documentation in Point Click Care progress notes in January 2014 indicates that the resident was receiving physiotherapy twice a week for 30 min of treatment. The most recent progress notes dated on March 2014 by the physiotherapist assistant does not have any data on the frequency of physiotherapy treatments for the resident.

Upon reviewing the physiotherapy daily attendance sheet, the resident was seen once a week in the month of March 2014 and there is no documentation either by the physiotherapist or physiotherapy assistant in the progress notes regarding the decrease in frequency of physiotherapy treatments that occurred between January 2014 and March 2014.

On April 23, 2014, the physiotherapist confirmed during an interview with LTCH Inspector #573 that the frequency of the physiotherapy treatments is not document in the resident’s plan of care for any of his/her residents in the home.

The resident written plan of care for the physiotherapy does not set out clear directions to the physiotherapy assistants and staffs who provide direct care to the resident regarding the frequency of the physiotherapy treatments that were delivered to the resident.

3. Throughout this inspection, a resident was observed to be seated in a tilt wheelchair with a front closing lap belt (also referred to as a seat belt). LTCH Inspector #573 reviewed the recent plan of care for the resident and under risk for falls it states “Safety equipment in use posey mat, side rails up when in bed and seat belt”.

In addition, throughout the inspection, another resident was observed to be seated in a tilt wheelchair with a front closing lap belt and a table top. LTCH Inspector #573 reviewed the recent plan of care for the resident and under risk for falls it states “Safety equipment in use padded split rails, posey mats, hi/low bed, seat belt, tabletop, non-slip footwear, curved mattress".

When LTCH Inspector #573 interviewed the RPN regarding the use of front closing lap belt for both residents, after reviewing the residents' plan of care the RPN was not able to confirm the use of front closing lap belt as a restraint or a PASD for either of the residents.

The written plan of care for both residents does not set out clear directions to staff and others who provide direct care to the resident regarding the use of front closing lap belt as a restraint or PASD. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. (3) (g) in that the licensee failed to ensure that the required information is posted in the home.

In accordance with the LTCHA 2007 s. 79. (1) the licensee shall ensure that required information shall be posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. S. 79. (3) outlines the specific required information to be posted and includes s. 79. (3) (g) which refers to notification of the long term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained.

Upon entry of the home on May 5, 2014, LTCH Inspectors #548, #547, and #573 completed an initial tour of the entire building and did not observe any posting indicating the home's policy to minimize restraining of residents and how a copy of the policy can be obtained.

LTCH Inspector #138 communicated with the Chief of Resident Care on May 7, 2014 who indicated that the home's policy to minimize restraining of residents was not posted due to an oversight. [s. 79. (3) (g)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s. 136.(3)(a) regarding drug destruction and disposal. The licensee specifically has failed to ensure that a drug that is a controlled substance is destroyed, it is done by a team acting together and composed of members as described by this section.

On May 12, 2014 LTCH Inspector #547 interviewed a staff member on a unit, concerning the medication destruction for the unit, whereby the registered nursing staff keep controlled substances in the narcotic locked drawer of the medication carts and if any are to be destroyed, the registered nursing staff highlight the substance packaging in pink, and also highlight in the narcotic book in pink. Registered nursing staff bring the controlled substances that are to be destroyed to the pharmacy during business hours with the narcotic book, and hand the substances to the pharmacist who then takes them away to be destroyed. The registered nursing staff confirmed that the staff do not witness the destruction of the controlled substances.

On May 13, 2014 LTCH Inspector #547 interviewed staff from an in-house pharmacy concerning the destruction process of controlled substances. The staff member indicated the pharmacist on duty will count the controlled substances to be destroyed with the registered nursing staff, and complete the Narcotic Administration Control

Sheet that is returned to the registered nursing staff member to return to the unit. The pharmacist on duty will take the controlled substances from the registered nursing staff to the back room of the pharmacy and destroy them with water and soap. This staff member stated this process was completed alone.

On May 13, 2014 LTCH Inspector #547 interviewed the manager for the in-house pharmacy concerning the procedure for medication destruction and disposal regarding controlled substances. The manager stated that the expectations would be a team of registered nursing staff or Director of Care in LTC and the pharmacist to destroy controlled substances together at all times.

Upon review of the pharmacy policy and procedure manual for LTC Homes section 5-Handling of Medication, policy 5-4 Drug Destruction and Disposal with revision date 01/14 indicates:
Monitored Medications (narcotic or controlled drugs) are destroyed by the team of physician or pharmacist and a nursing staff delegate and medications are considered destroyed when they are altered to such an extent that their consumption is rendered impossible or improbable.

On May 14, 2014 LTCH Inspector #547 interviewed the Director of Resident Care concerning the procedure for medication destruction and disposal regarding controlled substances in the home. The home's expectation would be that the destruction of the controlled substances would be done with the registered nursing staff and the pharmacist in the home. The Director of Resident Services indicated that she was informed 3 weeks ago from her registered nursing staff that they did not witness the destruction of controlled substances with the pharmacist. The Director of Resident Care spoke to the lead pharmacist for the home however their procedure has not been changed.

As such the licensee has not ensured that when a drug that is to be destroyed is a controlled substance, that it will be done by a team acting together and composed of members as indicated in this section. [s. 136. (3) (a)]

2. The Licensee has failed to comply with O.Reg 79/10, s.136 (3)(b) drug destruction and disposal. The licensee has specifically failed to ensure that where a drug that is to be destroyed is not a controlled substance, is not being done by a team acting together.

On May 12, 2014 LTCH Inspector #547 interviewed a registered nursing staff member on a unit, indicating that staff place all medications that are non-controlled substances to be disposed for destruction, in a hole in the counter that leads to a drum inside the locked cupboard of the locked medication room. The registered nursing staff indicated that staff do not assist in the destruction of these non-controlled substances as pharmacy come and take away the drums from every unit. The staff member further indicated they document within the e-MAR (electronic medication administration record) system if a medication has been refused, discontinued, expired as the medication is placed in a whole state or within a bottle in the locked drum.

On May 13, 2014 LTCH Inspector #547 interviewed a registered nursing staff member in another unit indicating that staff place all medications that are non-regulated substances to be destroyed in a hole in the counter that leads to a drum inside the locked cupboard of the locked medication room. Staff #116 indicated that registered nursing staff note the disposal of this medication in the home's e-MAR system indicating the reason it was disposed. The staff confirmed that no other staff witness this medication disposal or take part in any destruction of these medications in this surplus drum.

On May 13, 2014 LTCH Inspector #547 observed the drum containing the disposed non-controlled medications to be in a whole state mixed with closed bottles for medication.

On May 13, 2014 LTCH Inspector #547 interviewed with the pharmacist in the home indicating that they do not collect the non-controlled medication surplus drums from the resident care units, as this is done by the Continuous Quality Improvement Associate department. The pharmacist indicated that if the pharmacy receive non-controlled medication for disposal, it is kept in a back room of the pharmacy in a surplus drum.

On May 13, 2014 LTCH Inspector #547 interviewed the Continuous Quality Improvement Associate who is responsible to pick up all the surplus drums from every nursing medication room on every resident care unit and brings them all to a locked room located on the 2nd floor service corridor next to mechanical room 3. The Continuous Quality Associate reported to LTCH Inspector #547 that these non-controlled medication drums are taken off site to be destroyed from their whole state monthly by Stericycle.

On May 13, 2014 Inspector #547 interviewed a registered technician from the home's pharmacy reporting that they accompany a representative from Stericycle to the locked room on the 2nd floor storage area for pick-up of approximately 14-20 drums that require off site and appropriate medication destruction. The drums are covered, and the representative from Stericycle often will step on the lid to ensure it is properly installed. LTCH Inspector #547 did not observe any locking mechanism on these lids to prevent these drums from opening.

On May 13, 2014 LTCH Inspector #547 interviewed a new pharmacy manager with the home's pharmacy being oriented to the home who reported that the pharmacy Policy and Procedure Manual for LTC Homes indicates that a team of a pharmacist or physician and Director of Resident Services or delegated registered nursing staff regarding observation of the destruction of controlled substances. This same policy also indicates that all surplus non-controlled medications are destroyed by the team of registered nursing staff and one other staff member appointed by the home.

On May 14, 2014 LTCH Inspector #547 interviewed the home's Director of Resident Care who confirmed that she has not directed registered nursing staff to act as a team in having another staff member witness the disposal and destruction of non-controlled medications within the home.

In accordance with O.Reg 79/10, s.136 (6) a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

As such, the licensee has failed to ensure that where a non-controlled substance is to be destroyed, that it should be done by a team acting together composed of the members as described by this section. [s. 136. (3) (b)]

WN #6: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10 s. 229 (10) 1 in that each resident admitted to the home was not screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The home's Infection Control Coordinator and a charge nurse indicated to LTCH Inspector #573 that it is the home's practice to use the 2 step tuberculin skin test (also know as the 2 step mantoux test) for their tuberculosis screening program.

A review of newly admitted resident's health care record shows that the home did not screen for tuberculosis within 14 days of admission to the home.

Specifically, a resident was admitted to the home in February 2014. The first step of the 2 step mantoux test was administered sixty seven days after admission and the second step mantoux test was administered several days after that.

On May 13, 2014 the Infection Control Coordinator and a charge nurse confirmed during an interview with LTCH Inspector #573 that the resident was not screened for tuberculosis within 14 days of admission. They also confirmed there is no documentation regarding why the tuberculosis screening test was not done within 14 days of admission the for this resident.

A second resident was admitted to the home in September 2013. The first step and second step of the 2 step mantoux test were administered in February 2014.

The resident's progress notes in October 2013 in Point Click Care indicates that the resident refused the tuberculosis step 1 skin test. The resident's progress notes did not indicate that any follow up actions were taken or any further attempts made by the home to ensure tuberculosis screening was done for the resident, until February 2014 at which time the resident had received step 1 of the mantoux test. [s. 229. (10) 1.]

Issued on this 16th day of May, 2014

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