Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 1, 2016	2016_381592_0023	008282-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
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Long-Term Care Home/Foyer de soins de longue durée

THE SALVATION ARMY OTTAWA GRACE MANOR
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELANIE SARRAZIN (592), GILLIAN CHAMBERLIN (593)

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 19, 20, 21, 22, 23 and 26, 2016

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Director of Care (ADOC), Director of Food Services, Dietitian, Activity Director, Housekeeping Aide, Assistant Physiotherapy, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Chair of Family Council, a member of Residents' Council, family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, staff work routines, observed resident rooms, observed resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident

On September 20, 21 and 22, 2016, resident #008 was observed by Inspector #593 to be seated in a wheelchair with a seatbelt applied.

A review of Resident #008's current written plan of care found an intervention documented: uses a seatbelt which he/she is unable to unfasten.

A review of resident #008's health care record found a physician's order dated on a specified date in May 2016, documented - seatbelt to be used as PASD for comfort when up in wheel chair. A further physicians order dated 30 days after, documented - use seatbelt for safety when in wheelchair.

A review of resident #008's progress notes found multiple entries related to the use of the seatbelt:

On a specified date in September 2016- MDS Assessment- Seatbelt for safety.

During an interview with Inspector #593, September 22, 2016, resident #008 replied "no" when asked if he/she was able to undo the seatbelt, adding "I want to get up".

During an interview with Inspector #593, September 22, 2016, PSW #110 reported that the resident had a seatbelt when in his/her wheelchair as he/she was at risk for falls. PSW #110 added that initially the resident was able to unfasten the seatbelt himself/herself, however has probably not done this for at least one year.

During an interview with Inspector #593, September 22, 2016, RPN #104 reported that resident #008 used a seatbelt when in his/her wheelchair as he/she was at high risk for falls. RPN #104 added that every so often he/she would become fidgety and try to stand up however he/she was unable to unfasten the seatbelt.

During an interview with Inspector #593, September 22 2016, the Acting DOC reported that when determining whether a physical device was a PASD or a restraint, they were required to look at the intent of the device. In this situation, where the intent is for safety and to prevent falls and the resident was unable to unfasten the device, then it was considered a restraint. [s. 6. (1)]

2. On September 20 and 22, 2016, resident #018 was observed by Inspector #592 to be seated in a wheelchair with a physical device applied to his/her lower limbs.

Upon a review of resident #018's health care record, it indicated that resident was admitted in 2015 with several diagnosis. The health care records further indicated that resident #018 had an injury to a specified body part during the summer of 2016.

On September 22, 2016, in an interview with PSW #102, she indicated to Inspector #592 that the physical device used for resident #018 was requested by the resident's family member following a recent injury to maintain good body alignment while sitting in the wheelchair. RPN #102 further told Inspector #592 that the instructions were to apply the physical device, whenever the resident was sitting in his/her wheelchair.

In an interview with RPN #108 and the physiotherapist assistant #116, both indicated Inspector #592 that the resident was using the physical device for therapeutic use to maintain good body alignment due to some problems with an injury.

Upon a review of resident #018 current written plan of care under positioning, the current written plan of care does not indicate the use of the physical device while resident #018 is up in his/her wheelchair.

In an interview with the ADOC, she indicated to Inspector #592 that she was not able to find any documentation for the use of the physical device for resident #018 but that it was the home's expectations that the plan of care sets out the planned of care for resident #018 regarding the use of any physical/therapeutic devices. [s. 6. (1) (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 there is a written plan of care for resident #018 and resident #008 that sets out, the planned care when using specific equipment to promote body alignment and to include physical device in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device. Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg.79/10, s.110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

On September 20, 21 and 22, 2016, resident #014 was observed by Inspector #592 up in

his/her wheelchair with a seatbelt.

In a review of the resident health care records, resident #014 no longer ambulates and was assessed as needing a seatbelt when in his/her wheelchair to prevent him/her from falling.

On September 22, 2016, during an interview with PSW #109, she indicated to Inspector #592 that resident #014 was up in his/her wheelchair daily with a seatbelt attached at all times. She indicated to Inspector #592 that the resident needed to be checked every two hours to ensure that the restraint was well applied. She further indicated that PSWs were to document when the restraint was applied to the resident, when the device was released and repositioning of the resident and then the removal of the device. PSW #109 indicated that the staff are to document these areas by putting a check mark in the specified areas on the resident's flow sheet located in their Point of Care (electronic documentation).

On September 22, 2016, during an interview with RPN #106, she indicated to Inspector #592 that resident #014 was using a seatbelt daily for his/her safety and due to neurologic disorder putting him/her at risk for falls. She further told Inspector #592 that there was a restraint monitoring form for PSWs to use for the monitoring of restraints located in the "POC". RPN #106 further told Inspector #592 that the documentation had to include the application and removal of the restraint, when the resident was repositioned and hourly visual checks. Upon a review of the POC documentation, RPN #106 and Inspector #592 were not able to find any restraint documentation for resident #014.

On September 22, 2016, during an interview with the ADOC, she indicated to Inspector #592 that the expectation was that when a resident was using a physical device that PSWs were to document in their "POC" when the restraint was applied to the resident, when the device was released, the repositioning of the resident and then the removal of the device and hourly checks. Upon asking the ADOC for the documentation for the use of the physical device for resident #014, the ADOC was unable to provide any documentation. She further indicated to the Inspector that she was just made aware that the task has never been activated in the "POC" system for resident #014; therefore no documentation had been completed since the resident first started using the device. [s. 110. (7)]

2. On September 20 and 22, 2016, at 0830 hours, resident #018 was observed sitting in

his/her wheelchair with a seatbelt .

In a review of the resident health care records, resident #018 no longer ambulates and was assessed as needing a seatbelt when in his/her wheelchair to prevent resident from falling.

On September 22, 2016, during an interview with PSW #102 , she confirmed with Inspector #592 that resident #018 is up in the wheelchair daily with the seatbelt attached at all times. She further indicated to Inspector #592 that otherwise resident would try to get out of his/her chair and that he/she is not able to walk. She further told Inspector #592 that resident #018 had a recent fall which caused an injury to a specific body part. She indicated to Inspector #592 that she was verifying resident #018's seatbelt before breakfast, then around 10:30 and after lunch and at the same time, she was repositioning the resident. She further indicated to Inspector #592 that she was doing a last round at the end of her shift to ensure that the physical device was well applied. PSW #102 told Inspector #592 that staff are to document the use of the physical device in the "POC".

During an interview with RPN #108, she indicated to Inspector #592 that resident #018 was using a seatbelt daily requested by a family member since the resident had a fall resulting in an injury of a specific body part. She further indicated to Inspector #592 that the PSWs were responsible to document the time when the physical device was applied to the resident, when the device was released, the repositioning of the resident and the removal of the physical device. She further told Inspector #592 that the expectation is that all residents should be monitored every hour and repositioned every two hours.

Upon a review of the documentation on the restraint flow sheet in the "POC" for resident #018 for September 20, 2016, Inspector #592 observed numerous omissions in the documentation.

-it was noted that resident #018 safety device was applied at 1104 hours, 1400 hours and 2213 hours.

No documentation was found for the release and the repositioning of the restraint every 2 hours while awake for resident #018 other than 1400 hours and 2213 hours for that period of time.
No documentation was found for the monitoring of the resident safety device until 2213 hours on that day.
No documentation was found for the resident's response when using the physical device

for that day.

The restraint monitoring flow sheets were also reviewed from September 1 to September 20, 2016 and it was noted that the "POC" system does not allow the PSW to document the resident's assessment/reassessment and monitoring which include the resident's response when using physical devices.

On September 22, 2016, upon a review of the restraint flow sheets documentation with RPN #106, she confirmed with Inspector #592 that there were some omissions to the documentation for the day of September 20, 2016 for resident #018. She told Inspector #592 that when PSWs document in the "POC", the task is documented in real time, therefore the documented time is when PSW entered the task rather than when the task was completed. She confirmed that there was no place to document the resident's assessment/reassessment and monitoring which include the resident's response when using physical devices on restraint flow sheets.

On September 22, 2016, in an interview with the ADOC she indicated to Inspector #592 that the restraint flow sheets were the same one used for all the residents and the only place for PSWs to document. She further indicated that she was not aware that there was no place to document the resident's assessment/reassessment and monitoring which include the resident's response when using physical devices on restraint flow sheets on the restraint flow sheets. [s. 110. (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 that there is documentation when a physical device is use to restrain a resident, to be implemented voluntarily.

WN #3: 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 has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On September 20, 2016, Inspector #592 observed in a shared resident's bathroom the following:

1) One jar of a prescribed topical cream on top of the counter
2) One jar of an additional prescribed topical cream on top of the toilet

The two prescribed creams were identified to belong to resident #011.

Upon review of resident #11's health care records, it indicated that the resident was identified with a decline in intellectual functioning characterized by; deficit in memory, judgment and decision making.

On September 20, 2016, in an interview with PSW #100, she indicated to Inspector #592 that the two prescribed creams were for resident #011 and was used by PSWs and registered nursing staff. She further indicated to Inspector #592 that both creams should have been stored in the medication room.

On September 20, 2016, RPN #101, indicated to Inspector #592 that the prescribed creams were kept in the residents' washrooms especially when creams were required to

be applied on a daily basis. She further told Inspector #592 that other creams that were not to be applied on a regular basis were kept in the medication cart.

On September 21, 2016, ADOC indicated to Inspector #592 that no residents were allowed to keep medications in their rooms as all the medications should be stored and locked in the medication cart or the medication room. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On September 21, 2016, at 0756 hours, during a medication cart observation on a specific home area, Inspector #592 observed in the first drawer of the medication cart, one and a half tablet in a medication cup container belonging to resident #022.
Inspector #592 further observed in the second drawer of the medication cart, one tablet in a medication cup container belonging to resident #023.
Inspector #592 also observed in the second drawer of the medication cart, two other tablets in a medication cup container belonging to resident #024.

During an interview, RPN #104 indicated to Inspector #592 that the tablet observed for resident #022 was identified as a controlled drug. She further indicated to the Inspector that the tablet observed for resident #023 was also identified as a controlled drug. RPN #104 further indicated to Inspector #592 that the two tablets observed for resident #024 were identified as controlled drugs and that all the medications observed were prepared ahead for the residents. She further indicated that these medications were to be kept in a separate locked area within the lock medication cart.

During an interview the ADOC, indicated to Inspector #592 that the home's expectation is that all controlled substances should be stored in the separate locked area within the medication cart and not removed from this locked area until it is ready to be administered. [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 that prescribe cream are stored in an area that is secure and locked and that controlled substances are store in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a member of the registered nursing staff permits a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, has been trained by a member of the registered nursing staff in the administration of topical.

On September 20, 2016, Inspector #592 observed in a share resident's bathroom the following:

1) One jar of a prescribed topical cream on top of the counter
2) One jar of an additional prescribed topical cream on top of the toilet

The two prescribed creams were identified to belong to resident #011.

On September 20, 2016, PSW #100, told Inspector #592 that the two prescribed creams were for resident #011 and was used by PSWs and registered nursing staff. She further told Inspector #592 that it was more convenient for PSWs to apply the prescribed creams, because resident #011 was requiring both creams on a daily basis.

On September 21, 2016, PSW #105 told Inspector #592 that the administration of topical creams was applied by the PSWs to their assigned residents. She further told Inspector #592 that she did not receive any training but by reading the label on the jar, she knew what to do.

On September 21, 2016, in an interview with RPN #103 and #104, both told Inspector #592 that only the registered nursing staff were permitted to administer topical drugs, therefore no prescribed creams were given to PSWs.

On September 21, 2016, in an interview the ADOC told Inspector #592 that there was no process in place in the home for the delegation of topical creams to PSWs, therefore no training was ever provided. She told inspector #592 that she was not aware that this practice was occurring. She further told inspector #592 that only the registered nursing staff were permitted to administer topical medications. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that staff member other than the Registered nursing staff have been trained by a member of the registered nursing staff before the administration of topical, to be implemented voluntarily.

WN #5: 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are 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 supervised by staff.

On September 19, 2016 at 0939 hours, Inspector #592 observed on the second floor on Parkdale home area one soiled linen room unlocked. The soiled linen room led to another area which had a panel indicating "nurse call system controllers". The door to this area was also observed to be unlocked and open. The soiled linen room also contained plastic containers and was accessible to residents with no staff supervision.

On September 19 at 0932 hours and on September 20 at 1010 hours, Inspector #592 observed on the second floor on Queens House home area, one storage room unlocked. The storage room was containing lifts and battery chargers, wheelchairs and one electrical panel and was accessible to residents with no staff supervision.

In an interview on September 21, 2016, the ADOC told Inspector #592 that all the storage rooms and the soiled linen rooms were considered as non-residential areas and were expected to be closed and locked at all times. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was reviewed by the Residents' Council.

During an interview with Inspector #593, September 22, 2016, the President of the Residents' Council, resident #006 reported that the home's menu cycle was not reviewed by the Residents' Council, instead being reviewed with the food committee which sits separately to the Residents' Council.

During an interview with Inspector #593, September 22, 2016, the Director of Food Services confirmed that the home's menu cycle was reviewed with the food committee and not the Residents' Council.

During an interview with Inspector #593, September 23, 2016, the Activity Director reported that the food section of the Resident Council meetings was taking up too much time in the meetings therefore they decided to implement a separate food committee. The Resident Council members were invited to the food committee meetings, however most of them have not attended. The Activity
Director further reported that it was during the food committee meetings that the home's menu cycle was reviewed and afterwards the minutes of the food committee meetings were read at the next Residents' Council meeting. [s. 71. (1) (f)]

WN #7: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the meal and snack times were reviewed by the Residents' Council.

During an interview with Inspector #593, September 22, 2016, the President of the Residents' Council, resident #006 reported that the meal and snack times were not reviewed with the Residents' Council; instead being reviewed with the food committee which sits separately to the Residents' Council.

During an interview with Inspector #593, September 22, 2016, the Director of Food Services confirmed that the meal and snack times were reviewed with the food committee and not the Residents' Council. Furthermore, meal and snack times were only discussed with the food committee when the home made changes to these times.

During an interview with Inspector #593, September 23, 2016, the Activity Director reported that the food section of the Resident Council meetings was taking up too much time during the meetings therefore they decided to implement a separate food committee. The council members are invited to the food committee meetings, however most of them do not attend. The Activity Director further reported that it was during the food committee meetings that the meal and snack times were reviewed and afterwards the minutes of the food committee meetings were communicated at the next Resident Council meeting. [s. 73. (1) 2.]

Issued on this 1st day of November, 2016

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

Original report signed by the inspector.