Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 23, 2016	2016_440210_0001	013815-15	Resident Quality Inspection

Licensee/Titulaire de permis

NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET NORTH YORK ON M2K 1E1

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

SENIORS' HEALTH CENTRE
2 BUCHAN COURT NORTH YORK ON M2J 5A3

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

SLAVICA VUCKO (210), JUDITH HART (513), SARAH KENNEDY (605), SUSAN LUI (178), SUSAN SEMEREDY (501)

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): January 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 2016

During the Resident Quality Inspection (RQI), the following critical incidents were inspected concurrently: 001350-14, 007651-15, 031521-15.

During the course of the RQI, the inspectors conducted an initial tour of the home, a dining observation, reviewed resident health records, reviewed relevant policies and procedures, observed medication administration, and observed staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Director of Care, Assistant Director of Care (ADOC), Acting Assistant Director of Care, RAI MDS Coordinator, Programs Coordinator, resident assessment instrument (RAI) minimal data set (MDS) coordinator, Food Service Supervisor, Registered Dietitian, Environmental Services Supervisor (ESS), environmental staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, activity staff, Social Services Worker (SSW), Human Resources Representatives, Staffing Coordinator, Residents' Council President, Family Council President, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **3 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. 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 ensure that the home, furnishings and equipment are kept clean and sanitary.

On January 13, 2016, observation by inspector #605 revealed a table top in the third floor sunroom (room #315) was soiled with dried whitish debris. On January 21, 2016, observation by inspector #210 revealed the debris was still there and this was confirmed by environmental staff #134.

On January 25, 2016, observation by inspector #210 revealed the kitchenette area in the fourth floor television lounge had dust build up on the baseboards at the edge of the floor and the bottom of baseboard on the left side of the fridge, dried liquid debris on the floor under the refrigerator door, and on the counter top. This was confirmed by the ESS.

Interview with the ESS confirmed the table in room #315 and the kitchenette on fourth floor were unclean. He/she confirmed that it is responsibility of every employee to make sure the home and furnishing is kept clean. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

Review of a critical incident report on an identified date, revealed resident #020 alleged an identified staff slapped him/her on an identified body part after asking for a beverage. This was reported to a student and was alleged to have occurred two months prior. The resident could not recall a specific date but indicated it occurred at a specific time. The report stated that the resident had told his/her family member about the incident.

Resident #020 reported these allegations to a student who wrote a statement on an identified date that revealed the "resident reported that he/she could pick the staff out", gave a description of the staff member and the incident made him/her feel "awful about this place".

Interview with resident #020 revealed he/she recalled being slapped by a staff member during a specific shift when he/she asked for a beverage and stated the staff member still works here but has never hit him/her since.

Interview with the Administrator and DOC revealed that there are only two written documents related to the home's investigation; one being the student's statement as above and the other a handwritten note with an identified date on it, from an interview with an identified staff who resembled the resident's description of the staff member who

allegedly slapped the resident. Review of the interview notes revealed the identified staff denied hitting the resident.

Review of progress notes for resident #020 revealed RN #17 spoke with the family member on an identified date, and told him/her that the resident had alleged a staff member hit him/her two months ago and the home was looking into the matter. Interview with RN #17 revealed he/she did not remember speaking to the family member about this particular incident and could not remember asking the family member if he/she had prior knowledge of the incident.

Interview with the Administrator revealed it is the home's practice to suspend a staff member with pay if they have been alleged to have abused a resident until the investigation is complete. It is also the home's practice to keep full investigation notes related to the incident that indicate the results of the investigation and all those that had been interviewed. The Administrator could not explain why no one had contacted the family member to see if he had any knowledge of the incident and could not explain why no other staff members were interviewed. The Administrator could not explain why the staff member who resembled the resident's description was not brought to the resident to either clear up any misunderstanding or for the resident to positively identify the staff member.

The Administrator and DOC confirmed that in this particular incident of alleged physical abuse the home did not keep investigative notes that would have explained why the home did or did not take action that would have been appropriate. It was also confirmed there was never any resolution of this allegation of physical abuse and this was not acceptable. [s. 23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are stored using methods which prevent food borne illness.

On January 25, 2016, observation revealed a refrigerator in the fourth floor television lounge kitchenette area that contained a carton of eggnog with a best before date of January 3, 2016, and three small containers dated January 8, 2016, with what looked like pureed food inside. On January 26, 2016, the inspector and FSS observed a container of yogurt with a best before date of November 2015, in a refrigerator in the second floor television lounge. In the third floor lounge refrigerator, there were many unlabelled items including a container of frozen green onions, frozen yogurt and an unlabelled lunch bag.

Interview with the FSS revealed that these fridges are for families to bring food in for residents but all food must be labelled with the resident's name and dated. Further, dietary staff and the FSS should be checking these refrigerators for unlabelled and outdated food and discarding them as appropriate. It was also observed and confirmed by the FSS that no one is monitoring the temperatures in these refrigerators.

Interview with the FSS revealed that if anyone had consumed the above mentioned eggnog and pureed snacks, they might have contracted a food borne illness. The FSS confirmed that the home was not taking measures to ensure all food is being stored safely by not monitoring these refrigerators for out of date food and ensuring that the temperature inside the refrigerator was at a level that would keep foods safe. [s. 72. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are stored using methods which prevent food borne illness, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
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 locked when they are not being supervised by staff.

On January 13, 26 and 27, 2016, observations revealed that room #110 on the first floor across from the nursing station had a key on a chain attached to the door and it was inserted into the door lock accessible to everyone. There was a sign on the door stating the washroom was for staff only and there was no call bell communication system installed in the washroom.

Interview with ADOC #103 indicated the washroom was not to be used by residents but staff only and there was a potential for residents to access the washroom. This was also confirmed by maintenance technician staff #116.

On the same dates, observations of room #480 on the fourth floor where an ice making machine was located, revealed a key attached to a chain on the door, accessible to everyone. There was no call bell communication system installed in the room.

Interview with the ESS revealed room #480 was not to be used by residents but by staff and family members only. He/she confirmed that he/she removed the keys from room #110 and #480 and ordered a different locking system for both rooms. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent receives an assessment that includes identification of causal factors, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A review of resident #006's resident assessment instrument (RAI) minimal data set (MDS) assessments from identified dates in 2015, indicated the resident was occasionally incontinent of bowels, and frequently incontinent of bladder. A review of the flow sheets indicated during an identified period in 2016, when the resident was at the home, he/she was incontinent of bladder all the time and three out of eight times he/she was continent of bowels.

Interview with RN staff #115 indicated when a resident is incontinent he/she should be assessed using the Bladder and Bowel Continence Assessment form that is located in the electronic documentation. The nursing staff member #115 confirmed resident #006, who was occasionally incontinent of bowels and frequently incontinent of bladder, was not assessed using the clinically appropriate assessment instrument Bladder and Bowel Continence Assessment that the home has designed it specifically for assessment of incontinence. [s. 51. (2) (a)]

2. A review of resident #014's resident assessment instrument (RAI) minimal data set (MDS) assessment on an identified date indicated the resident was frequently incontinent of bladder and occasionally incontinent of bowel. Interview with RPN staff #113 confirmed resident #014's is frequently incontinent of bladder and occasionally incontinent of bowel since admission.

A review of resident #014's paper and electronic record revealed that there was no documentation of a continence assessment, using a clinically appropriate assessment instrument that was specifically designed for assessment of continence.

Interviews with RPN staff #115 and RPN RAI Coordinator staff #127 confirmed that since admission, no continence assessment was conducted for resident #014. ADOC #002 confirmed an assessment for incontinence should be completed on admission, annually, and with a change in condition that impacts bowel or bladder continence. [s. 51. (2) (a)]

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that the required information is 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. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is 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.

As per section 79 (3) (k) of the Long Term Care Homes Act, the required information to be posted includes copies of the inspection reports from the past two years for the long term care home.

Observations during the initial tour of the home on January 14, 2016, revealed that all of the inspection reports from within the past two years were not posted in the home. Inspection reports #2014_357101_0026 and #2015_321501_0003 were not posted within the home.

The Administrator confirmed that the two inspection reports were not posted within the home. [s. 79. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion of the investigation.

Review of the home's investigation notes and resident #020's progress notes indicated no one had notified the resident and the resident's SDM regarding the results of the alleged physical abuse investigation that commenced on an identified date, when the resident told an identified student staff that an identified staff had slapped him/her.

Interviews with resident #020 and the resident's SDM revealed no one from the home had contacted them about the results of their investigation regarding the above mentioned allegation of physical abuse.

Interviews with the Administrator, DOC, Social Services Worker, and RN #117 confirmed they had not contacted resident #020 or the resident's SDM regarding the results of the home's investigation of the above mentioned incident and there was no evidence that anyone else from the home had done so. [s. 97. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home was considered in the evaluation of the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

Review of the home's written evaluation of the prevention of abuse and neglect program from February 2014 to February 2015 revealed the committee did not analyze any incident of abuse or neglect. Interview with the Administrator confirmed this was the last annual evaluation of the prevention of abuse and neglect policy and that if it was not indicated in the report then no incident of abuse or neglect of a resident was considered in the evaluation. [s. 99. (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the critical incident report includes analysis and follow-up action, including the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

A review of a critical incident report (CIR)submitted on an identified date indicated resident #001 eloped into one of the stairwells, sustained injuries and was sent to the hospital for further assessment. In the CI report to the Director the home indicated that they would further investigate to determine how the resident got into the stairwell. The incident report was amended but did not indicate that the home performed analysis and follow up for the elopement. The resident had another incident of elopement into the same stairwell on a later identified date, with no injuries sustained.

Interview with the DOC and ESS revealed the reason for not addressing the above mentioned issues may have been due to frequent power failures in 2014 and the electric magnetic locking (maglock) system not being connected to the generator in case of power failure. He/she was able to present documents that the maglock system was inspected on an identified date by Electrical Safety Authority (ESA) and serviced on two occassions several months later.

A review of the CIR and interview with the DOC and ESS confirmed that the CIR did not include analysis and follow up action including the immediate actions that have been taken to prevent the elopement recurrence, and the long-term actions planned to correct the situation and prevent recurrence. [s. 107. (4) 4.]

WN #10: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On January 18, 2016, observation of resident #30's bed side table revealed a tube of medicated cream.

On January 26, 2016, RPN #132 and RN #115 confirmed that there was no physician prescription, in consultation with the resident, for the medicated cream to be located at resident #30's bedside for self-administration by the resident. [s. 131. (5)]

WN #11: 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. (8) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and O. Reg. 79/10, s. 229 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place an outbreak management system for detecting, managing and controlling infectious disease outbreaks specifically related to ESBL (extended spectrum beta-lactamase) that included defined staff responsibilities.

According to Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for surveillance of health care-associated infections in patient and resident populations. 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2014, ESBL is an Antibiotic-Resistant Organism (ARO): A microorganism that has developed resistance to the action of several antimicrobial agents and that is of special clinical or epidemiological significance (e.g., MRSA, VRE, ESBL, CPE).

A review of the home's policy Disease Protocols-Required Level of Precautions Based on Clinical Syndrome and Conditions, IX-H-10.00 (a) dated January 2015, for the organism Extended –Spectrum Beta Lactamase producing Enterobacteriaceae (ESBL) indicated that contact precaution may be indicated, single room may be indicated, and the duration of precaution, if indicated, are initiated and discontinued by Infection Control. The Infection Control leader is to be notified.

A review of resident #006's plan of care indicated the resident's urine culture was ESBL positive on an identified date in 2015. The resident was treated with antibiotics and on a later identified date the urine culture was ESBL negative. A review of the infection prevention and control (IPAC) record with the IPAC leader indicated the resident was ESBL positive since an identified date approximately two years ago. Observation on January 18, 2016, indicated no sign for contact precaution on the door of the resident room.

Interview with RN staff #115 and IPAC leader #102 indicated a resident is placed on contact precautions when the microbiology specimen is positive for ESBL and the resident has signs and symptoms of infection. The contact precautions are discontinued when the resident does not have signs and symptoms of infection or the microbiology result is negative. Presently there are seven residents in the home that were colonized with ESBL from which three were treated for signs and symptoms of infection and four are still colonised in the rectum since two years ago. The contact precautions for all positive ESBL residents were discontinued in December 2015 by the two IPAC leaders. There is no process in place for ESBL rescreening.

According to Provincial Infectious Diseases Advisory Committee (PIDAC) best practice guideline, Annex A, 2013: Screening, Testing and Surveillance for Antibiotic-Resistant Organisms (AROs), In All Health Care Settings, one of the listed recommended interventions for non-acute care settings, in addition to routine practices, is to discontinue the contact precautions for ESBL, when there are negative results from all colonized/infected body sites (e.g., three consecutive negative cultures taken at least one week apart) in the absence of antibiotic therapy.

A review of the IPAC program/policies and interview with the IPAC leader confirmed that the home has not developed written procedures that included how staff were to detect, manage and control ESBL in the home. Specifically, the licensee did not include a written procedure if the residents are to be screened for ESBL at admission and when the staff are to initiate and discontinue contact precautions according to best practice guidelines and evidence based practices. [s. 229. (8) (a)]

Issued on this 25th day of February, 2016

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

Original report signed by the inspector.