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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 4, 2016	2015_353589_0026	035009-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. CLAIR O'CONNOR COMMUNITY INC
2701 St Clair Avenue East East York ON M4B 3M3

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

ST. CLAIR O'CONNOR COMMUNITY NURSING HOME
2701 St Clair Avenue East East York ON M4B 3M3

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

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), STELLA NG (507), 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): December 15, 16, 17, 18, 22, 23, 24, 29, 30 and 31, 2015.

The following log numbers #022919-15 and #001166-15 were inspected concurrently with this resident quality inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Staff, Personal Support Workers (PSW), Program Manager (PM), Dietary Aide (DA), Physio Aide (PA), Substitute Decision Maker (SDM), Toronto Public Health Nurse (TPH), Residents' Council and Family Council Presidents.

During the course of the inspection, the inspector(s) reviewed clinical records, observed resident care areas, resident care, staff and resident interactions, meal service, reviewed Family and Residents' Council meeting minutes and relevant policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

10 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

On December 16, 2015, observations by the inspector revealed gaps at the foot and head of beds located in two identified rooms.

Record review of a bed entrapment audit conducted in July 2015, by Shoppers Home Health Care (SHH) revealed the following zone entrapment issues:
-two beds in two identified rooms with zone 7 entrapment risk.

The SHH audit further revealed that the Waterloo Pressure-Pedic mattresses which were two of the shortest and seemingly the oldest in the two identified rooms be discarded and replaced with ones that were 84 inches long and had reinforced transfer edges.

On March 17, 2008, Health Canada released the publication of the final Guidance Document Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards. This Guidance Document is intended to assist manufacturers in understanding and complying with the regulatory requirements of sections 10-21 of the Medical Devices Regulations as they pertain to the design and directions for use for hospital beds.

The guidance document provided recommendations intended to reduce life-threatening entrapments associated with hospital bed systems. It characterized the body parts at risk for entrapment, identified the locations of hospital bed openings that are potential

entrapment areas, and recommends dimensional criteria for these devices. The term "hospital bed system" encompasses the bed frame and its components, including the mattress, bed side rails, head and foot board, and any accessories added to the bed.

Zone 7 is the space between the inside surface of the head board or foot board and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot boards. FDA recognizes this area as a potential for entrapment and encourages facilities and manufacturers to report entrapment events at this zone.

On December 24, 2015, observations of the above mentioned rooms were conducted with the DOC and he/she confirmed there were gaps between the foot and head of the above mentioned beds that posed entrapment risks and that steps had not been taken to prevent resident entrapment. [s. 15. (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 where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Record review of an incident report on an identified date in March 2014, revealed resident #004 had an incident when being transferred from a lounge chair to wheelchair while being assisted by one staff. Resident #004 slid off the lounge chair and landed on an identified body area. Initial assessment by registered staff #013 revealed no significant injury had been sustained. At 1600 hours registered staff #110 transferred resident #004 to hospital for increased complaints of pain in an identified body area.

Review of progress notes for an identified date in March 2014, revealed resident #004 had sustained an injury that required surgical repair.

Record review of resident #004's care plan dated March 14, 2014, under the transferring focus revealed resident #004 required a two person assist for transfers and the use of assistive equipment to support transfers.

Record review of the home's internal investigation and sentinel event analysis revealed that PSW #114 had transferred resident #004 unassisted.

Interview with DOC confirmed PSW #114 had not used safe transferring technique. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 failed to ensure that the following immunization and screening measures are in place:
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.

Review of the Toronto Public Health (TPH) recommendations for Tuberculosis (TB) Screening in Long Term Care (LTC) and Retirement Homes updated on February 14, 2013, revealed that Tuberculin skin tests (TST) are not recommended to be done upon admission for residents 65 years of age or older. A review of the Canadian TB Standards, 6th edition (CTS 2007) advises that residents 65 years of age and older of LTC Institutions undergo baseline posterior-anterior and lateral chest X-rays.

Health record review of resident pre-admission and post-admission immunization records for the following three residents revealed they had not received any TB screening either 90 days prior to admission or within 14 days of admission:
-resident #006, admitted on an identified date in July, 2015,
-resident #016, admitted on an identified date in September, 2015,
-resident #017, admitted on an identified date in June, 2015.

Interview with Toronto Public Health (TPH) nurse #108 revealed that the home is to follow the TPH TB screening recommendations that were issued to all long term care homes on February 14, 2013.

Interviews with the DOC and the home's Infection Control Lead #101 confirmed that the home's Infection Prevention and Control Program is not in accordance with evidence-based or prevailing practices related to their TB screening program. [s. 229. (10) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Residents Service Concerns/Complaints policy is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation 103. (1) states that every licensee that receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10. S. 103 (1).

Record review of the home's policy titled: Residents Service Concerns/Complaints, policy number NUR-1-014; dated June 8, 2015, states that when a complaint is received a resident service response form is to be completed by any person receiving a complaint or concern.

The purpose of the policy is to:
-have a system in place to monitor unresolved concerns/complaints,
-ensure feedback to our residents, families and staff,
-ensure corrective actions are taken and noted on the appropriate response form in a timely manner and,
-meet resident's expectations in a timely manner and Ministry of Health and Long Term Care Standards.
The home's policy does not provide direction to report under section 24 of the ACT any written complaint to the Director.

Interviews with the DOC and interim ED revealed a written complaint was received by the former Executive Director (ED) on an identified date in July, 2015. The complaint included areas of concern related to basic nursing care for resident #018.

Interview with the interim ED confirmed the above mentioned policy is not in compliance with and has not been implemented in accordance with all applicable requirements under section 24 of the Act. [s. 8. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan includes an order by the physician or the registered nurse in the extended class.

On December 16, 22 and 23, 2015, observations by the inspector revealed the use of a restraint for resident #008 when he/she was up in a mobility aid.

Interviews with registered staff #100 and PSW #106 revealed that the restraint is applied when resident #008 is up in the mobility aid for safety. They further revealed that resident #008 is dependent for his/her activities of daily living (ADL) and cannot remove the restraint on his/her own.

Record review of resident #008's health record revealed a consent for the use of a restraint when up in the wheelchair was signed by the substitute decision maker(SDM)on an identified date in December, 2014.
Record review of the three month medication review (TMMR) for resident #008 on an identified date in November 2015, revealed an order for the use of a restraint was not written. Further review of the physician orders revealed there was no restraint order written for the use of a restraint when resident #008 was up in the mobility aid.

Interview with the DOC confirmed that the restraint plan of care for resident #008 did not include an order by the physician. [s. 31. (2) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, has the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of the home's policy titled: Fall Prevention, policy number NUR-XVI-073-A, with a review date of April 15, 2011, indicated under post fall assessment and management, an incident report and a fall risk assessment screening tool are to be completed to investigate cause of fall.

Record review of of resident #004's written plan of care revealed a post fall assessment (fall risk screening tool) was not completed after a fall incident on an identified date in March, 2015, that resulted in a transfer to hospital where resident #004 sustained an injury to an identified body area.

Interview with DOC confirmed that a post fall assessment for resident #004 was clinically indicated related to increasing complaints of pain and, was not completed using the home's clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

Census record review for the following residents revealed that annual heights were not taken:
-resident #009, height last taken on an identified date in June, 2010,
-resident #011, height last taken on an identified date in April, 2014,
-resident #012, height last taken on an identified date in June, 2013,
-resident #013, height last taken on an identified date in September, 2010,
-resident #014, height last taken on an identified date in June, 2010 and,
-resident #015, height last taken on an identified date in June, 2010.

Interview with the DOC confirmed that the above mentioned resident's heights were not completed annually. [s. 68. (2) (e) (ii)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Record review of the Residents' Council meeting minutes for 2015, revealed no indication that the home consulted the Residents' Council regarding the development and implementation of the survey.

Interview with the Residents' Council President revealed that the Residents' Council had not been involved in developing and carrying out the satisfaction survey.

Interview with the Residents' Council assistant #103 confirmed that the home did not consult with Residents' Council in 2015, regarding the development and implementation of the satisfaction survey. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with.

Record review of the Family Council meeting minutes revealed a written complaint dated on an identified date in July, 2015, was received by the former Executive Director (ED). The complaint included areas of concern related to basic nursing care for resident #018.

Interview with the DOC revealed that he/she became aware of this complaint after reading Family Council meeting minutes of October 2015, where the complaint had been initially brought forward. The meeting minutes further revealed the complaint had been sent directly to the former ED. The chair of the Family Council provided the DOC with a copy of the letter in early November 2015. To date the DOC was not aware if the concerns had been investigated or if any response had been provided to the complainant.

Interview with the interim ED revealed he/she has been at the home since November 2, 2015, and became aware of this complaint when the DOC brought the complaint letter to him/her the week of December 21, 2015.

Interview with the Interim ED confirmed there is no record of any investigation or response provided to the complainant. [s. 101. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10. S. 103 (1).

Record review of complaint letter dated July 16, 2015, addressed to the former ED revealed areas of concern related to basic nursing care for resident #018.

Interviews with DOC and the interim ED revealed and confirmed there was no written record of this complaint being reported to the Director nor a written report documenting the response the licensee made to the complainant. [s. 103. (1)]

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.