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

Division des foyers de soins de longue durée
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
Feb 1, 2017	2017_321501_0001	035011-16	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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600)

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 4, 5, 6, 9, 10, 11, 12, and 13, 2017.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Food Service Manager (FSM), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide, Resident's Council President, Family Council President, Activationist, Pharmacist, residents and substitute decision makers.

During the course of the inspection, the inspectors conducted observations in home and resident areas, observation of care delivery processes including medication passes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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. 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

During stage one of the inspection resident #006 triggered through the Minimum Data Set (MDS) for continence decline and incontinence worsening.

Review of resident #006's MDS assessment revealed the resident was frequently incontinent and he/she needed total assistance by two staff to toilet.

Review of the physiotherapy staff follow up documentation in progress notes indicated resident #006 had been referred to the physiotherapist (PT) regarding safety when using a lift during the toileting process. The PT recommended the resident be changed in bed and not be toileted on a toilet for safety concerns related to falls.

Review of resident #006's written plan of care for toilet use revealed the staff were not to toilet resident #006 on a toilet because of identified concerns. However, review of the resident's written plan of care for continence care revealed inconsistency in giving direction to staff. One intervention directed staff to not leave the resident unattended on the toilet and another intervention directed staff to encourage the resident to go to the bathroom when he/she has urge to void.

Observation of PSW #108 on January 12, 2017, indicated the PSW was preparing resident #006 to toilet him/her on a toilet. Interview with the PSW confirmed that he/she had been told by full time staff that the resident should be toileted on the toilet and that was what he/she was doing.

Interview with Registered Nurse (RN) #104 confirmed resident #006 was not to be toileted on a toilet, was not able to go to the toilet without assistance, and was not able to feel the urge to void. The RN confirmed the directions were very confusing for the staff to follow.

Interview with the DOC confirmed staff who update the resident's written plan of care are expected to provide clear direction to the direct care providers as how to provide care to the residents. Further he/she confirmed resident #006's plan of care directions were confusing for the staff to follow. [s. 6. (1) (c)]

2. The home has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that the different aspects of care are integrated, consistent with and complement each other.

Resident #006 triggered from stage one of the inspection for eating decline. Review of resident #006's MDS assessment of an identified date, revealed the resident declined in eating self-performance from extensive assistance to total dependence.

Observations on January 9 and 10, 2017, revealed resident #006 was fed by staff and was served a textured modified diet. Record review revealed the written plan of care

stated the resident needs extensive assistance with feeding and is to receive a specified textured diet and nutrition intervention, unless the resident appears lethargic in which case provide an alternate textured diet.

Interviews with PSW #106 and 108 and dietary aide #109 revealed resident #006 is on the alternate textured diet. Interview with the FSM revealed the resident receives the alternate textured diet 99 per cent of the time but on the off chance he/she is able to consume the specified textured, the diet has not been changed. The FSM did confirm that the resident would be safer on a textured modified diet. The FSM stated he/she had not referred the resident to the Registered Dietitian (RD) to assess diet texture.

Record review revealed the last assessment made by the RD for resident #006 was on an identified date, when there was no indication of problems in the areas of tolerating the specified textured diet and needing total assistance with feeding. An interview with the RD revealed he/she was not referred to resident #006 for difficulty with the specified textured diet or needing more assistance.

Interviews with the FSM and DOC confirmed it is the practice in the home to collaborate with the RD whenever there are changes in a resident's ability to chew, swallow and feed oneself. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of resident #006's plan of care.

Resident #006 was triggered by MDS assessment in stage one of the inspection for continence decline and incontinence worsening comparing to the admission assessment.

Review of resident #006's MDS assessment revealed the resident was frequently incontinent and he/she needed total assistance by two staff to toilet him/her.

Review of the resident's written plan of care for toilet use revealed resident #006 cannot be toileted on a toilet due to various concerns and would therefore be at risk for falls. Review of the physiotherapy staff follow up documentation in progress notes indicated resident #006 had been referred to the Physiotherapist (PT) regarding safety using a lift during toileting. The PT recommended the resident be changed in bed and not be toileted on a toilet for safety concerns related to falls.

On January 12, 2017, the inspector observed PSW #108 preparing resident #006 to be

toileted on the toilet. An interview with the PSW revealed he/she was not aware the resident is not to be toileted on the toilet as he/she was unaware of what the plan of care was for toileting resident #006. The PSW told the inspector that he/she had been told by another PSW that the resident should be toileted on the toilet.

Interviews with Personal Support Workers (PSWs) #107, 108, and 110, revealed they were not aware of the contents of the plan for care for resident #006 regarding continence care and toilet use. The interviews confirmed they had not read or reviewed the resident's written plan of care and they did not know what the directions were for resident #006 regarding continence care and the use of the toilet.

An interview with the DOC confirmed staff that provide direct care to the residents are expected to be aware of the contents of the plan of care on ongoing basis. [s. 6. (8)]

4. The licensee failed to ensure that the resident is reassessed and plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #006 triggered from stage one of the inspection for eating decline. Review of resident #006's MDS assessment revealed the resident declined in eating self-performance from extensive assistance to total dependence.

Observations on January 9 and 10, 2017, revealed resident #006 was fed by staff and was served a textured modified diet. The resident was served food on a regular plate.

Review of the eating section of the written plan of care revealed the resident needs extensive assistance with feeding and staff to implement interventions to assist resident with eating In the nutritional status section of the written plan of care the resident is to receive the specified textured diet with a nutritional intervention unless he/she appears lethargic, in which case, an alternate textured can be served. The resident is to receive food in an identified assistive device.

Review of the physician's orders revealed resident #006's diet was the specified diet texture and alternate texture as needed. Review of the diet list revealed the resident's diet was the specified diet texture with nutritional intervention and alternate texture on request.

Interviews with the FSM and dietary aide #109 revealed resident #006 receives a texture

modified diet most days. Interviews with RN #104 and the RAI Coordinator revealed resident #006 is no longer able to feed him/herself and is totally dependent on staff.

Interviews with the FSM and RD confirmed that the resident no longer needs an assitive device to aid with eating because he/she is now fed.

Interviews with RN #104, the RAI Coordinator, FSM, RD, and DOC confirmed resident #006's plan of care was not reviewed and revised when the resident's care needs changed or care set out in the plan of care was no longer necessary. [s. 6. (10) (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 the plan of care sets out clear directions to staff and others who provide direct care to the resident, to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that the different aspects of care are integrated, consistent with and complement each other, to ensure that staff and others who provide direct care to a resident are kept aware of the contents of residents' plan of care, and to ensure that the resident is reassessed and plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

Findings/Faits saillants :

1. The home has failed to ensure that the locks on washrooms are designed and maintained so that they can be readily released from the outside in an emergency.

An observation on January 4, 2017, revealed there was a lock on the washroom door in room #304. Further observations throughout the inspection revealed that washroom doors in rooms #306, 307, 308, 309, 311, 313, 315, 317, 319, 321 and 322 also had locks on them.

An interview with PSW #105 revealed he/she was unaware of how to unlock these doors in an emergency. An interview with RN #104 also revealed he/she was unaware of how to unlock these doors and called maintenance who provided a device that could be inserted into the locking mechanism that would render the door unlocked.

Interviews with the DOC and ED confirmed that these locks and staff being unaware of how to unlock them posed a risk to residents. The ED stated the locks will be removed. [s. 9. (1) 3.]

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 locks on washrooms are designed and maintained so that they can be readily released from the outside in an emergency, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

During the initial tour on January 4, 2017, inspector #600 observed a soiled utility room unlocked. On January 6, 2016, inspector #501 observed the same door slightly open. Further observation revealed chemicals were stored underneath the sink that included Antibacterial All Purpose Cleaner and Heavy Duty Alkaline Bathroom Cleaner. The label on the bathroom cleaner stated, "do not drink."

An interview with RN #104 revealed that this door should be kept locked because there is a resident that does try to go in there and there are chemicals stored within. Interviews with the ED and DOC confirmed this door should be kept locked in order to keep all hazardous substances inaccessible to residents at all times. [s. 91.]

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 hazardous substances are kept inaccessible to residents at all times, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Review of resident #006's progress notes revealed the resident sustained an identified type of altered skin integrity on a specified date. Interview with the RD revealed he/she did not receive a referral to assess this altered skin integrity.

Review of the home's policy #DTY-XI-320 titled Dietitian Referral effective May 2014, states that a Registered Dietitian Referral is used for whenever there is a change in residents' status, when RAI outputs affecting eating have occurred and/or when RAI-MDS quality indicators affecting nutritional intake are triggered that require a review of the current nutrition interventions by the RD. RAI-MDS quality indicators affecting nutrition status include the prevalence of stage I-IV pressure ulcers.

Ontario Regulation 79/10 under section 50(2)(b)(iii) requires that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds be assessed by a registered dietitian who is a member of the staff of the home.

Interviews with the RD and DOC confirmed that the home's policy only indicates the RD is to be referred when a resident has a pressure ulcer and not for when residents have altered skin integrity, including skin breakdown, skin tears and wounds. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #003 was triggered by MDS assessment in stage one of the inspection for new altered skin integrity comparing to the previous full assessment.

Review of the MDS assessment revealed resident #003 needed extensive assistance by two staff for bed mobility and total assistance by two staff for transfers and toileting. The resident had altered skin integrity and he/she was on a turning and repositioning program. Review of the resident assessment protocol (RAP) for the same period indicated resident #003 had been identified at high risk for altered skin integrity.

Review of resident #003's progress notes for an identified time period, revealed the resident developed altered skin integrity on an identified body area after the resident was returned from the hospital. Further the progress notes review failed to reveal if the altered skin integrity had been healed, however on an identified date, the altered skin integrity reoccurred.

Review of resident #003's plan of care revealed the resident had been identified as at risk for skin breakdown related to urinary incontinence. One of the interventions was to reposition resident #003 every two hours and to encourage the resident to use side rails to assist with turning.

Review of resident #003's Observation/Flow Sheet Monitoring Form completed by the PSWs for four consecutive months, failed to reveal documentation for the turning and repositioning intervention.

Interview with the RAI Coordinator indicated the electronic monitoring system had a section where PSWs could document the turning and repositioning intervention on the end of the shift.

Interview with PSWs #106 and 108 revealed they turned and repositioned resident #003 but they did not document as the turning and repositioning intervention was not set up in the electronic monitoring system for them to document.

Interviews with RN #114 and RPN #112, indicated that they observed and assisted the staff to reposition the resident but they were not aware that the PSW had not documented the intervention.

An interview with RN #104 confirmed there was no documentation for the turning and repositioning interventions for resident #003. The RN revealed that before the PSWs started documentation in the electronic monitoring system, they had a hard copy documentation tool for turning and repositioning that they would complete after each intervention.

Interview with the DOC confirmed staff are expected to document each intervention in the electronic monitoring system. The DOC stated he/she will follow up with their electronic monitoring system team to make sure the turning and repositioning tool is available for PSWs. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds be assessed by a registered dietitian who is a member of the staff of the home.

Review of resident #006's progress notes revealed the resident sustained altered skin integrity on an identified date, and was not assessed by the RD. Interviews with RN #104, the FSM, RD and DOC confirmed the resident was not assessed by the RD for altered skin integrity. [s. 50. (2) (b) (iii)]

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 has failed to ensure that the nutrition care and hydration programs include the identification of any risks related to the nutrition care.

Review of the home's policy #DTY-XI-320 titled Dietitian Referral effective May 2014, states that a Registered Dietitian Referral is used for whenever there is a change in residents' status, when RAI outputs affecting eating have occurred and/or when RAI-MDS quality indicators affecting nutritional intake are triggered that require a review of the current nutrition interventions by the RD. RAI-MDS quality indicators affecting nutrition status do not include any abnormal blood levels.

Review of resident #006's progress notes revealed the resident had abnormal blood levels. On an identified date, the level was at a specified level and the physician started the resident on supplements daily for three months and to recheck values. On an identified date, the resident's blood level was at a specified level and the physician resumed the order for supplements. There was no indication the RD assessed this abnormal blood value.

Interviews with RN#104 and the RD revealed sometimes the physician will refer abnormal laboratory values to the RD however not in all cases. Interview with the FSM revealed he/she usually refers abnormal laboratory values to the RD but does not know why he/she did not do so in this case.

Interviews with the RD and DOC confirmed the nutritional care program does not include the identification of the risk of abnormal blood values to nutrition care on a consistent basis. [s. 68. (2) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

Interviews with the Residents' Council President and Assistant revealed the home does not communicate quality improvements to the Residents' Council. Review of the Residents' Council meeting minutes for 2016 did not reveal any communication regarding quality improvements. Interview with the ED and DOC confirmed the home has not communicated improvements made through the quality improvement and utilization review system to accommodations, care, services, programs and goods provided to the residents of the Residents' Council. [s. 228. 3.]

Issued on this 7th day of February, 2017

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

Original report signed by the inspector.