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
Nov 4, 18, 2016	2016_382596_0014	027125-16	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

TRUE DAVIDSON ACRES
200 DAWES ROAD TORONTO ON M4C 5M8

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

THERESA BERDOE-YOUNG (596), ANGIE KING (644), JUDITH HART (513)

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 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 27, 28, 29, 30, 2016.

The following Critical Incident (CI) intakes were inspected concurrently with this RQI: 018621-15, 002699-15, 026016-15, 025438-16, 024362-15.

The following Complaint intakes were inspected concurrently with this RQI: 022489 -15, 004997-15, 01815-15, 025613-15, 005027-16, 006871-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), nurse managers (NM), social worker (SW), registered dietitian (RD), occupational therapist (OT), housekeeping staff, registered nurses (RN), registered practical nurses (RPN), consulting pharmacist, support assistant (SA), CCAC staff member, previous manager, practical care aides (PCA), Family Council Chair, Residents' Council Chair, Residents' Council Vice-Chair, residents and family members.

During the course of the inspections, the inspectors toured the home, observed resident care, observed staff to resident interactions, reviewed health records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

- **5 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in the plan of care was provided to the resident as specified in the plan.

Record review of an anonymous complaint called into the Ministry of Health and Long Term Care (MOHLTC) Infoline in September 2015, reported that the home was understaffed, staff were calling in sick and as a result there was poor care.

Record review of the home's nursing staff schedules and interview with the support assistant (SA) revealed that staff worked short of one scheduled registered staff 41 times, and short of a practical care aide (PCA) four times throughout the months of August, September and October 2015. The staff also worked short one scheduled registered staff five times, and short of a PCA three times between September 1- 23, 2016; they were unable to replace the scheduled staff who did not come in to work.

On a specified date in September 2016, on the fourth floor west unit, a PCA did not come in for a scheduled short shift on the day shift, and as a result the unit was understaffed for the shift.
Record review of the fourth floor west unit's staff assignment sheet (day shift) revealed an identified resident should receive bathing on two specified days of the week. Record review of the resident's Nursing and Personal Care Record (NPCR), under the Bathing section for a specified date in September 2016 was not signed off.

Interview with PCA #135 revealed that he/she was assigned to provide care for the identified resident in addition to his/her regular resident assignment, since they were working one PCA short on the day shift on the above mentioned specified date in September 2016. PCA #135 stated that he/she had to go back and forth between two units to provide resident care and there wasn't enough time to complete the identified resident's bathing and documentation. He/she forgot to inform the nurse that bathing wasn't offered to the resident.

Interview with nurse manager (NM) #112 confirmed that staff were expected to provide care as indicated in residents' plans of care, and when staff work short and are reassigned to residents accordingly, the expectations remain the same. NM #112 stated that a bed bath should have been offered to the identified resident on the above mentioned specified date in September 2016, and if unable to for any reason the registered staff should have been informed. [s. 6. (7)]

2. Record review of an anonymous complaint called into the MOHLTC Infoline in September 2015, revealed that the home was understaffed, staff were calling in sick and as a result there was poor care.

Record review of the home's nursing staff schedule revealed that on a specified date in September 2016, the scheduled registered staff for the fifth floor east unit, evening shift did not come in to work.

Interviews with the fifth floor west nurse and fourth floor east nurse, RPN #146 and #161 revealed that RPN #161 helped out by administering medications during the evening shift medication pass, to residents on the fifth floor east.

Record review of an identified resident's physician's medication review included an order for a particular medication, to be taken by mouth twice daily (hold if a vital sign is below a certain parameter). Record review of the identified resident's Medication Administration Record (MAR) on the above mentioned specified date revealed no staff sign off for administration of the medication during the evening shift medication pass, and no documentation of the resident's vital sign.

Interview with RPN #161 revealed that he/she could not remember if he/she administered the particular medication mentioned above for the identified resident, on the evening shift of the specified date. RPN #161 stated that it was busy and he/she had

to work on two floors (fourth and fifth) since they were working short of one registered staff. RPN #161 reported that he/she did not remember holding the particular medication mentioned above, and he/she documented the resident's vital sign on the Resident shift report.

Record review of the fifth floor Resident shift report and the identified resident's progress notes did not include documentation of the resident's vital sign during the evening shift on the above mentioned specified date in September 2016.

Interview with NM #112 confirmed that there was a back up staffing plan that is implemented when staff have to work short (PCA or registered staff), where other registered staff assist. The expectation was that care is provided as per residents' plans of care and documented, and staff should inform the charge nurse if they encountered any challenges with completing the resident care assigned to them. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the 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.

During stage one of the Resident Quality Inspection (RQI), continence and bowel management triggered for an identified resident.

Record review of an identified resident's MDS assessment dated August 28, 2016, indicated that resident was total dependence with two staff for assistance with toileting. The written plan of care stated that the resident wore a medium sized brief and directed staff to toilet the resident twice on the day shift and twice on the evening shift, for bladder and bowel.

Interviews with PSW #101 on the day shift and PSW #100 on the evening shift revealed that they do not toilet the resident as reflected in the plan of care. PSW #101 reported that the identified resident was very stiff and he/she only assisted the resident with toileting during shower time, and PSW #100 reported that the resident was very stiff, mostly incontinent of bladder and bowel so he/she changes resident's incontinent product in bed with assistance by another staff member. PSW #100 stated that the identified resident's care plan needed to be reviewed and updated. [s. 6. (10) (b)]

4. During stage 1 of the RQI minimizing of restraints triggered for an identified resident. The inspector observed the resident's bed with one quarter bed side rail up.

Record review of the identified resident's assessment for bed mobility dated May 2016, completed by the Occupational Therapist (OT) and the resident's written plan of care reflected the use of two quarter bed side rails for bed mobility and transfers.

Interview with the OT confirmed that he/she discussed the use of bed side rails with the identified resident's Power of Attorney (POA), since the resident was cognitively impaired, and updated the written plan of care with the above mentioned information after completing the assessment.

Interview with PSWs #100 and #101 revealed that the identified resident used one quarter bed side rail for bed mobility and transfers. PSW #100 reported that he/she would follow up with the nurse to ensure that the care plan gets updated to reflect one bed side rail. [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 care set out in the plan of care was provided to the resident as specified in the plan, and that the resident was reassessed and the 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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Record review of a Critical Incident (CI) report submitted in August 2015, revealed a controlled substance was missing for an identified resident and that the end of shift count was completed by one staff on an identified date in August 2015. The evening registered staff RPN #132 and RPN #119 who were counting the narcotic discovered that two tablets were missing.

A review of the home's medication policy from the Pharmacy manual titled Narcotics Control, policy number PH-0106-00, revised date March 1, 2006, in the Policy Procedure section five, stated that two nurses, one from the outgoing shift and one from the oncoming shift, will count narcotics utilizing Narcotic Record by recording the declining balance on the Narcotic Record.

A review of the identified resident's Medical Pharmacies Combined Monitored Medication Record with Shift count narcotic on a specified date in August 2015, at 1515 hours revealed on the count for the oral narcotic tablet, signatures from the incoming and outgoing nurses were missing for the day and evening shift change count.

Interviews with RPN #119 and RPN #132 revealed that at the start of their shift the count had been completed on the above mentioned specified date in August 2015, at 1515 hours, and that the 1445 hours column for the starting staff signature area was blank; they reported that they both signed in that area in error.

A review of the discipline letter dated September 15, 2015, for RPN #121 who had worked the day shift acknowledged that on the above mentioned specified date in August 2015, at 1445 hours he/she had not counted the narcotics with a second registered staff present at end of shift.

Interview with Director of Care (DOC) #117 and NM #127 revealed that it was the home's expectation to have two nurses complete the shift change count of the narcotic medications, and sign on the count sheet after conducting the count. The DOC confirmed that staff #121 did not comply with the home's Narcotic Control policy. [r.8. (1) (b)] [s. 8. (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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that after receiving the assessments and information as required under subsection 43 (6), that the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

In February and March 2016, the MOHLTC received complaints related to the refusal of admission to a long-term care (LTC) home. An identified resident was a long-term resident of the home, had been hospitalized, and was requesting transfer back to the

LTC home. A review of the progress notes for the identified resident revealed that she/he was admitted to the home on a specified date in November 2008, admitted to hospital on a specified date in May 2015, for an extended period, and subsequently discharged from the home two months later.

Record review of the letter from a specified date in February 2016, from the Administrator to the identified resident, withheld approval for admission to the home. The ground cited was, “your care needs require a level of nursing expertise that we are unable to provide.”

A review of Community Care Access Centre (CCAC) Behavioural Assessment Tool of a specified date in December 2015, revealed the identified resident had significant behavioural issues when first admitted to hospital but they had settled down, and there had been no documentation about physical aggression in nurses notes since admission to hospital

Interviews with the Administrator and DOC revealed that the home had a responsive behaviour program that was effective and that staff received annual responsive behaviour educational training. An interview with the DOC confirmed there was no level of nursing expertise that could not be provided to residents by the home, and the responsive behaviour program was appropriate for the present management of the identified resident's responsive behaviours.

In addition, the information provided as supporting facts for the identified resident in the aforementioned licensee letter reflected two dates in May 2015. These dates preceded the resident’s transfer to hospital approximately three weeks later. No requirements for care were provided by the licensee.

The Administrator and DOC did not provide sufficient evidence that the staff of the home lacked the nursing expertise necessary to meet the identified resident’s care requirements. [s. 44. (7) (b)]

2. In August 2015, the MOHLTC received a complaint related to the refusal of admission to a long-term care (LTC) home.

A review of the letter from a specified date in June 2015, from the administrator to an identified resident, withheld approval for admission to the home. The ground cited was, “your care needs require a level of nursing expertise that we are unable to provide.” No

requirements for care were provided by the licensee.

The identified resident was living in the community. A review of psychiatric consults on a specified date in July 2013, revealed aggressive behaviour toward his/her spouse. Record review of progress notes for the identified resident reflected that the resident was noted to have severe impairment, responsive behaviours and no aggression since July 2013. Further notes indicated the resident was sent to hospital for further assessment.

A review of Community Care Access Centre (CCAC) Behavioural Assessment Tool of a specified date in May 2014, revealed the resident wandered and could be verbally redirected; he/she had not been verbally or physically aggressive towards his wife since July 2013, sometimes refused to take medications and staff re-approach at another time. A review of the medical report of a specified date in March 2014, indicated the resident no longer had serious behavioural disturbances.

Record review of a CCAC Behavioural Assessment Tool of a specified date in December 2014, revealed the identified resident had exhibited anxious behaviour in predictable situations triggered by wife. No physical or verbally abusive behaviours were noted. No evidence was located that there was aggression or abusive behaviours to any person other than this resident's spouse.

Interviews with the Administrator and DOC stated the home had a responsive behaviour program that was effective and that staff received annual responsive behaviour educational training. An interview with the DOC confirmed there was nursing expertise and other resources for responsive behaviours in the home.

The Administrator and DOC did not provide sufficient evidence that the staff of the home lacked the nursing expertise necessary to meet the identified resident's care requirements. [s. 44. (7) (b)]

WN #4: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence care and bowel management program, at a minimum, provided for an annual evaluation of residents' satisfaction with the range of continence care products, in consultation with residents, substitute decision-makers and direct care staff.

Record review of the home's annual satisfaction evaluation of continence care products for 2015 and interview with the DOC and Administrator confirmed that it did not include consultation with residents and substitute decision-makers. [s. 51. (1) 5.]

WN #5: 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 has failed to ensure to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the Residents' Council Chair and Vice-Chair revealed that the licensee did not seek the advice of the Council in developing and carrying out the satisfaction survey in 2015. Record review of the home's Residents' Council meeting minutes from January 2015-November 2015 did not reflect that the home sought the advice of the Residents' Council.

Interview with the Administrator reported that the Residents' Council assistant could not remember if the home sought the advice of the Residents' Council in developing and carrying out the satisfaction survey in 2015, and the home was unable to provide any supporting documentation. [s. 85. (3)]

Issued on this 29th day of November, 2016

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

Original report signed by the inspector.