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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d’Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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 17, 2016	2016_288549_0005	001109-16	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL OTTAWA HEALTH CARE GROUP
1141 Carling Avenue OTTAWA ON K1Z 7K4

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

ROYAL OTTAWA PLACE
1145 CARLING AVENUE OTTAWA ON K1Z 7K4

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

RENA BOWEN (549), LISA KLUKE (547), MEGAN MACPHAIL (551)

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 25, 26, 27, 28, 29, February 1, 2, 3 ,4, 5, 2016

During the Resident Quality Inspection a Complaint Inspection Log # 036232-15 was completed related to a complaint regarding bathing and staffing concerns, two Critical Incident Inspections Log # 003710-15 and #025981-15 were completed related critical incident reports the home submitted regarding abuse and transfer to hospital. There was also a Follow Up Inspection Log # 009765-15 related to a staff training order.

During the course of the inspection, the inspector(s) spoke with residents, the President of the Residents' Council, the President of the Family Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeeping Aides (HSKP), the Housekeeping Supervisor and the Housekeeping Manager, a Recreation Therapist, a Dietary Aide (DA), a Human Resources Officer, a Maintenance Worker, an Administrative Clerk, an Office Co-ordinator, the homes Facility Services Manager, the Director of Care(DOC) and the previous Administrator, the current Administrator and the home's Director.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 76.	CO #002	2015_286547_0005	547

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, furnishing and equipment were kept clean and sanitary.

Numerous observations made throughout the inspection supported that the home, furnishing and equipment were not kept clean and sanitary, including but not limited to:

- Room South(S) 206:

On January 27, 2016, it was noted that there was orange colored splatter and a dried substance on the wall of the resident's room, near the entry to the washroom, and there was dust and debris along the perimeter of the wall.

On February 4, 2016, the Housekeeping Manager, the Housekeeping Supervisor and the inspector entered room S206.

The Housekeeping Supervisor indicated that the splatter on the wall should have been removed as part of regular housekeeping. The Housekeeping Manager indicated that the presence of debris along the perimeter of the room was because the housekeeper assigned to this floor used a micro fibre mop to clean the floors. She indicated that a regular mop would lift the debris. Room North 313 was visited and was noted to have a ring of brown along the perimeter of the wall. This room is cleaned by a housekeeper who uses a regular mop. The Housekeeping Supervisor indicated that the debris appeared to have been waxed over and into the flooring.

On February 5, 2016, the inspector observed that the splatter and dried substance remained on wall, and that there was dirt and debris on the floor, including around the perimeter of the room. The dirt and debris was very prevalent to the left of the resident's bed, near a bedside table.

On February 5, 2016, the floor in room S206 washroom, was observed to be in disrepair by the inspector, this was discussed with Maintenance Worker #126. The majority of the flooring was noted to be discolored, when compared to an area under the garbage can which was off white, and was colored brown and black. The area of discoloration was very prevalent next to the toilet. The Maintenance Worker #126 indicated that the flooring was not a maintenance issue and was able to lift some of the brown and black markings, identified as dirt, with a washcloth and soap.

Housekeeper #118 indicated that room S206 was deep cleaned on a specific day of the week (which would have been the day before the initial observations) and spot cleaned daily.

Unclean flooring was also noted by the inspection team in the following resident rooms and/or washrooms: S202, S203, S204, S209, S212, S305, S314, S316, N309, N310, N313.

- Corridors

Throughout the course of the inspection, the flooring in the hallways, in both the north and south sections of the home and on both floors, was observed to have dark colored matter along the corridor between the end of the baseboard and the wall, and to have dust and debris in the corners along the walls.

The Manager of Housekeeping indicated that there was a part-time housekeeper assigned to clean hallways and common areas during the week, and that on the week-end, the responsibility was divided between two housekeeping staff members. The Manager and Supervisor of Housekeeping were shown the base board outside of the south dining room on the second floor which had a layer of dirt. The Manager of Housekeeping indicated that the cleaning of corners was considered to be project work and that this was above and beyond normal cleaning routines.

- Wheelchair

On January 27, 2016, it was observed that resident #024’s wheelchair frame and seat cover was covered in debris. On February 3, 2016, the resident’s wheel chair was observed to be heavily soiled with white spots and food particles. According to PSW #121, night shift staff are responsible for cleaning residents’ wheelchairs and walkers. According to the cleaning schedule, the resident’s wheel chair was to be cleaned on a spcific day of the week(which would have been the night before the initial observation). On February 5, 2016, it was observed that the resident’s wheel chair frame and seat cover were covered in debris, pencil shaving and food particles. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishing and equipment were maintained in a good state of repair.

Numerous observations made throughout the inspection supported that the home was not maintained in a good state of repair, including but not limited to:

Third floor: Outside of the lounge in north and south units, there is a crack in the floor tiles extending across the hallway (approximately seven tiles). In the south hallway, the crack runs across the length of the door frame. Cracked floor tiles were noted to run across the hallway between the servery and the entrance to the dining room, and for approximately fourteen tiles in front of the nurses' station.

Second floor: Outside of the south spa, there is a crack in the floor tiles extending approximately fifteen tiles. Across from the lounges and rooms C205 and S201, cracked floor tiles run across the hallway.

South 201: On January 27, 2016, a scuffed wall with exposed metal was noted near the entrance to the resident's washroom.

South 206: On January 27, 2016, a scuffed wall with exposed metal was noted near the entrance to the resident's washroom, and scuff marks on walls were noted throughout the resident's room.

South 209: On January 26, 2016, scuffed walls and flooring were noted throughout the resident's room and washroom. There were rust marks on the raised toilet seat and plaster work patches on the wall in the washroom.

South 212: On January 26, 2016, scuffed walls in the resident's room were noted.

South 204: On January 27, 2016, scuffed walls and a crack in the plaster in the corner of the resident's room were noted.

South 312: On January 26, 2016, peeling paint was noted on the inside of the room door and black matter was noted in the caulking surrounding the washroom sink.

North 310: On January 26, 2016, scuffed walls were noted in the resident's room.

North side, third floor: On February 5, 2016, white plaster work was noted on the orange wall below the bulletin board, on the opposing wall and extending intermittently down the hallway. Chips and scuffs in the walls were noted intermittently throughout the corridor.

South side, second floor: On February 5, 2016, white plaster work was noted on the yellow paint between rooms N206 and N207 and a gash in the wall was noted between N 210 and N224.

During a phone interview with the Facility Services Manager, he indicated that there was a plan in place to repair the cracked floor tiles and that the time line was by the end of the fiscal year which was March 2016.

In an interview with Maintenance Worker #126, he indicated that in a recent audit, he had identified sixty seven resident rooms and washrooms that required patching and painting. He indicated that once the work order is submitted, he does not have control as to when the painter comes in to complete the jobs, and estimated that approximately 40% of the home could use fresh paint, in order to improve the state of repair of the home. [s. 15. (2) (c)]

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, sanitary and maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of a between meal beverage in the morning and afternoon, and a snack in the afternoon.

On the second floor beverages and snacks are offered three times daily in the south side dining area. According to, PSW #107, residents on the unit know to come to this area for nourishment, but if they do not come, they are not offered a beverage or snack as part of the organized nourishment pass.

On February 2, 2016, the morning beverage pass and the afternoon nourishment pass were observed on the second floor.

At approximately 1020 hours (hrs), the eight to ten residents who were in the north side dining area getting ready for an activity were offered a beverage.

At approximately 1030 hrs, the nourishment cart was moved to the south side dining area.   Resident #027 and Resident #046 were seated in this area and were offered a beverage. Resident #020 who had been sitting in the area had left and gone back to his/her room before the nourishment cart arrived. He/she was not offered a morning beverage.

Residents on the unit who were not in the north or south dining areas were not offered a beverage in the morning.

At approximately 1440 hrs, there were six residents in the south side dining area who were offered a beverage and snack.

At this time, Residents #044, #045, #046, #010, #027, #025 and #047 were observed to be in their rooms and did not come to the south side dining area. These residents were not offered a beverage and snack.

The care plans for Residents #044, #045, #046, #010, #027, #025 and #047 were reviewed, and there was no indication that these residents were not to be offered a beverage and snack in the afternoon.

RPN #106 indicated that the practice on the unit is offer beverages and snacks to the residents who come to the designated nourishment area, and that those who do not come are not offered a beverage and snack at the nourishment passes. [s. 71. (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 each resident is offered a minimum of a between meal beverage in the morning and afternoon and a snack in the afternoon, to be implemented voluntarily.

WN #3: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

This finding is related to a Critical Incident.

On a specific day in March 2015 a Critical Incident Report (CIR) was submitted to the Director indicating suspected abuse/neglect of resident #012. The CIR also indicated that the investigation continues to determine the outcome.

During a telephone interview on February 2, 2016, the previous Administrator #113 who was in charge of the home at the time of the incident, indicated that she does not recall if the home reported the results of the abuse/neglect investigation of resident #012 to the Director as required.

The Human Resources Officer took part in the investigation of the suspected abuse/neglect of resident #012. During a telephone interview with the Human Resources Officer, on February 5, 2015 it was indicated to Inspector #549 that the investigation of the suspected abuse/neglect of Resident #012 concluded on a specific date in March 2015.

Inspector #549 verified on the Long Term Care Home Portal on February 5, 2016 that the CIR was not amended to include reporting of the results of the investigation of the suspected abuse/neglect of resident #012 to the Director. [s. 23. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable ground to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it is based to the Director.

This finding is related to a Critical Incident

Resident #12 was admitted to the home on a specific date in August 2004 with multiple diagnosis.

The Minimum Data Set (MDS) assessment dated a specific date in December 2014 indicated that resident #012’s cognitive skills for daily decision –making is moderately impaired, decisions poor; cues or supervision required. MDS data indicated that the resident’s transfers are assessed on how the resident moves between surfaces- to and from bed, chair, wheelchair and standing position. Resident #012 requires one person physical assist for transfers. The MDS also indicated that the resident is frequently incontinent of urine. Resident #012 was assessed to be a moderate risk for falls as indicated in the written plan of care dated a specific date in December 2014.

On a specific date in March 2015, PSW #114 observed the resident-staff communication and response system (call bell) cord for resident #012, between the mattress and the

frame of the bed with a pillow on top of the cord. PSW #114 indicated that the call bell was not accessible to resident #012. PSW #114 also indicated that resident #012's usual behaviour is to ring the call bell several times during the night for assistance to go to the washroom.

Inspector #549 reviewed resident #012's progress notes which indicated that the resident rang for toileting assistance 4 times during the night shift on a specific date in March 2015, four times during the night shift on a different specific date in March 2015 and eight times during the night shift on another specific date in March 2015.

Resident #012 indicated during an interview on February 2, 2016 that he/she recalls being upset that he/she could not reach his/her call bell so he/she got out of bed and used the call bell in the washroom. Resident #012 also indicated that he/she recalls the PSW was telling him/her that the bed was not wet when he/she knew it was and that he/she was assisted back to bed by the PSW when the bed was still wet. Resident #012 recalls being upset about the bed being wet and then fell back to sleep. Resident #012 does not recall who the PSW was.

During an interview on February 2, 2016 PSW #114 indicated she felt the incident was abuse of resident #012 and immediately reported it to both unit RPNs and the Charge RN. PSW #114 indicated that the Charge RN reported the incident immediately to the previous DOC #119.

During an interview with RPN #112 on February 2, 2016 she confirmed that the Charge RN called the previous DOC #119 to the second floor unit and an investigation of suspected abuse of resident #012 was immediately initiated by the previous DOC #119.

The home submitted a Critical Incident Report on a specific date in March 2015 indicating the suspected abuse/neglect of resident #012 which is two days after the previous Director of Care #119 became aware of the suspected abuse.

During a telephone interview on February 2, 2016 with the previous Administrator #113 who was in charge of the home at the time of the incident, confirmed with Inspector #549 that the home did not immediately report the suspected abuse/neglect of resident #012 to the Director as required. [s. 24. (1)]

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

This finding is related to a Critical Incident.

The home submitted a Critical Incident Report (CIR) on a specific date in March 2015 indicating staff to resident abuse/neglect of resident #012 on a specific date in March 2015.

The CIR indicated that the designated contact or substitute decision maker was not contacted due to resident #012's contact being Public Trustee and Guardian. Inspector #549 reviewed resident #012's health care file which indicated that resident #012 has a specific contact for Power of Attorney for Care (POC) that is not the Public Trustee and Guardian. Inspector #549 verified with the Office Coordinator #117 that resident #012 has a specific POC and verified the home has the contact information.

During an interview on February 2, 2016, the previous Administrator #113 who was in charge of the home at the time of the incident, indicated to Inspector #549 that resident #012's POC was not notified of the suspected abuse/neglect of resident #012. The previous Administrator also indicated that she is aware if resident #012 had Public Trustee and Guardian for care they would be required to be notified. [s. 97. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On February 1, 2016 Inspector #547 observed the medication cart on the third floor unlocked and unattended by a registered nursing staff on the north side corridor in front of the dining room windows at 0920 hrs. A bottle of medication prescribed for resident #036 was sitting on the top of this unlocked medication cart.

RPN #110 returned to the medication cart and indicated to Inspector #547 that she had left the cart quickly to attend to a resident down the north hallway. RPN #110 indicated that she forgot to lock resident #036's prescribed bottle of medication in the bottom of the medication cart or to lock this cart before going to assist another resident down the resident care hallway. RPN #110 further indicated that she is aware that the medication carts should always be locked when unattended for the safety of residents. [s. 129. (1) (a)]

Issued on this 17th day of February, 2016

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

Original report signed by the inspector.