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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 16, 2014	2014_235507_0012	T-264-14/T-550-14/T-718-14	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF HUMBER HEIGHTS
2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3

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

STELLA NG (507), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 11, 12, 13, 16, 17, 18 and 19, 2014.

Inspection for intake T-710-14 was conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the administrator/ acting environmental service manager, the director of nursing care (DONC), the assistant director of nursing care (ADONC), neighbourhood coordinators (NCs), registered nurses (RNs), registered practical nurses (RPNs), personal care assistants (PCAs), maintenance worker, registered dietitian (RD), food service manager (FSM), residents and substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of resident care, meal and snack service, staff-resident interactions, reviewed resident health records and the home's records, relevant policy and procedures, training materials and employee education records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 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 any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with.

The home’s policy titled Nutrition and Hydration revised April 2014, indicates that extra fluids consumed by the resident will be documented by the registered staff at the medication pass on the daily additional fluids chart. Each evening, the Nutrition and Hydration Flow Sheets will be tallied by the night personal care assistant (PCA) team, which will include the daily additional fluids chart. The night registered staff will review and initial the total daily fluid intake. Any resident who has a fluid intake less than the estimated fluid requirements will be reported to the oncoming registered staff so that interventions can be initiated.

An identified resident is identified at risk for dehydration. A review of the resident's nutrition and hydration flow sheets revealed that for an identified period of time, the resident’s fluid intake was below his/her individualized daily fluid requirement.

Interview with an identified PCA revealed that the identified resident requires assistance, encouragement and reminders to drink to ensure adequate hydration. The identified registered practical nurse (RPN) indicated that the resident receives additional water from the medication pass and confirmed that additional fluids from the medication pass and other sources have not been recorded for an identified month.

A second identified resident is identified at risk for dehydration. A review of the resident’s nutrition and hydration flow sheets revealed that for an identified period of time, the resident’s fluid intake had decreased. A review of the nutrition and hydration flow sheets for the resident revealed that additional fluids were not recorded for an identified month.

A further review of the nutrition and hydration flow sheets for the residents on two identified neighbourhoods revealed that for the identified month, additional fluids were not recorded.

The registered dietitian (RD) confirmed that the staff are not documenting additional fluids received by the resident on the resident nutrition and hydration flow sheets.

The RPN and the director of nursing care (DONC) confirmed that the night staff are required to tally the additional fluids into the total daily fluid section and staff are not documenting/recording the additional fluids which are supposed to include fluids from the daily med pass. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the home's Prevention of Abuse in Long-Term Care policy is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Section 24(1) of the Act states that a person who has reasonable grounds to suspect that any of the following has occurred or may occur to report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

Review of the home’s policy titled Prevention of Abuse in Long-Term Care revised November 2013, indicates any team member with reasonable grounds to suspect that any type of abuse or neglect has occurred, or may occur, must immediately report the incident to the team leader, charge nurse, immediate supervisor or any leadership team member in the building. Upon receiving a report of suspected abuse, the team leader will immediately involve their charge nurse and/or neighbourhood coordinator (NC). If after hours the charge nurse will advise the on-call leadership team member and will report the incident to the Ministry of Health and Long Term Care using the Mandatory Reporting Line.

This policy is not in accordance with the Act that states a person who has reasonable grounds to suspect that any abuse or neglect of a resident has occurred or may occur shall immediately report the suspicious and the information upon which it is based to the Director [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Nutrition and Hydration policy is complied with and the home's Prevention of Abuse in Long-Term Care policy is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who receive training in relation to the home's policy to promote zero tolerance of abuse and neglect of residents prior to perform their responsibilities, receive retraining annually as required by the regulations.

Review of the home's policy titled Prevention of Abuse in Long-Term Care revised November 2013, indicates that team members will receive annual training on abuse prevention. Record review revealed that 94.3% of all staff received training on abuse prevention in 2013. [s. 76. (4)]

2. The licensee failed to ensure that all staff at the home who have received training in relation to the duty under section 24 to make mandatory reports prior to perform their responsibilities, receive retraining annually as required by the regulations.

Section 24 of the Act requires a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff has occurred or may occur to immediately report the suspicion and the information upon which it is based to the Director.

Interviews with the assistant director of nursing care (ADONC), two registered staff and six PCAs revealed an unawareness of their duty to make mandatory reports to the Director under section 24 of the Act.

Staff interviews revealed that they would report any alleged abuse or neglect to their team leader, NC, nurse manager and the management would then report directly to the Ministry. Furthermore, the home's mandatory reporting training material did not include the duty under section 24 to make mandatory reports.

Record review revealed that 94.3% of all staff received training in mandatory reporting in 2013. [s. 76. (4)]

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 staff at the home who received training in relation to the duty under section 24 to make mandatory reports and zero tolerance of abuse and neglect of residents prior to performing their responsibilities, receive annual retraining as required by the regulations, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record in relation to the written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

Interview with an identified resident revealed that he/she has complained to the management of the home numerous occasions since admission regarding his/her care in relation to call bell response, staff not respecting his/her privacy, being rushed during care, staff’s infection prevention and control practices and the room air temperature.

Record review revealed that only one of the identified resident’s received complaints was documented in the home's complaints record; it included the nature of the complaint, the date the complaint was received and the type of action taken to resolve the complaint. However, it did not include the final resolution (if any), every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

Interviews with the administrator, the DONC, the ADONC and an identified NC confirmed that the home did not maintain a record of all the residents' verbal complaints, and that they were unable to verify the resident's verbal complaints were resolved within 24 hours. [s. 101. (2)]

2. On an identified date, an identified resident indicated that his/her roommate is loud, and sometimes keeps him/her up at night.

On an identified date, an interview with an identified PCA providing care to the identified resident revealed that the resident's roommmate speaks loudly and wakes the identified resident up early in the morning. According to the PCA, this is ongoing and upsets the identified resident. The PCA indicated that the identified resident complained to him/her approximately two weeks prior and the PCA told the resident to personally speak with the NC. Furthermore, the PCA indicated he/she reported the identified resident's concern to the NC.

A review of the identified resident's progress note revealed that between a period of three days, the resident's roommate was shouting and screaming at various times in the early morning.

An interview with the NC revealed awareness of the identified resident's complaint regarding the roommate being excessively noisy, yelling out in the early morning and waking the identified resident. The NC confirmed that the identified resident's

roommate continues to be noisy.

Record review revealed and interview with the NC confirmed that the identified resident's verbal complaint was not documented in the home's complaint record. [s. 101. (2)]

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 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 documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity.

On an identified date, during an interview with an identified resident, it was revealed to the inspectors that he/she overheard a staff member, standing outside his/her room and loudly saying "don't get stuck there". The resident did not feel he/she can trust anyone like that with his/her care.

An interview with the DONC confirmed that an internal investigation was conducted regarding the identified resident's complaint that he/she heard a team member shouting outside the door of his/her room to other staff member attending him/her not to take too long.

As a result of the home's internal investigation, the identified staff member was transferred to another neighbourhood. [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On an identified date and an identified time, the inspector observed that the door leading to the spa room in an identified neighbourhood was open and accessible. The door was wide open with a door stop; the inspector was able to gain access to hot water taps, equipment, and personal hygiene supplies on the cart and inside a bottom supply cabinet. For a period of 17 minutes, the spa room remained open and accessible. Furthermore, there was a pool of water on the floor by the tub area draining into the floor drain.

Interview with an identified registered staff confirmed that the door should be closed and locked at all times. [s. 5.]

WN #6: 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).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

On an identified date, during am snack on an identified neighbourhood, the inspector overheard a family member commenting to an identified PCA that an identified resident had not received his/her mid-morning labelled snack and that the resident had not received the snack for the entire week.

The resident's care plan indicates he/she is to be provided specific snack items daily at the am snack, and the resident is reported to have poor intake.

An interview with the registered staff confirmed that a request was sent to the dietary department about the resident's missing snack after immediately receiving a comment from the family member.

Interviews with the RD and the food service manager (FSM) confirmed that there has been a recent change in production software resulting in the resident's snack not being prepared according to the list for the past week. The FSM was observed to deliver the labelled snack to the resident shortly after. [s. 6. (7)]

WN #7: 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 failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On an identified date and time, the inspector observed in an identified neighbourhood spa room that the cabinet door hinges were loose and the doors were hanging off. The inspector brought the issue to the attention of the registered staff. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, on an identified lounge neighbourhood, the inspectors observed an identified PCA standing while assisting an identified resident who was seated in a wheelchair, with drinking. The resident was not safely positioned and was observed tilting his/her head upward while being assisted with drinking the beverage.

The resident's written plan of care identified the resident at risk for choking/aspiration episodes. The resident is to be positioned at 90 degrees for receiving food and drinks.

The identified PCA indicated he/she usually sits when assisting feeding in the dining room, and he/she does not apply the same technique when assisting with beverages in other areas of the home other than dining room.

The administrator confirmed that residents are to be seated so that they are at eye level with staff assisting in eating and drinking. [s. 73. (1) 10.]

Issued on this 23rd day of July, 2014

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