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
Dec 15, 2016	2016_382596_0017	032798-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Credit Valley Hospital and Trillium Health Centre
150 Sherway Drive ETOBICOKE ON M9C 1A5

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

McCall Centre Long Term Care Interim Unit
140 Sherway Drive ETOBICOKE ON M9C 1A4

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

THERESA BERDOE-YOUNG (596), JULIEANN HING (649)

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): November 21, 22, 23, 24, 25, 28 and 29, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), Residents' Council President, residents and family members.

During the course of the inspection, 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:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

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

Record review of the identified resident's bladder continence assessment, revealed that he/she had not been assessed using a clinically appropriate assessment instrument specifically designed for assessment of incontinence when he/she was admitted in July 2016.

Interview with registered nurse (RN) #104 and the Director of Care (DOC) confirmed that the identified resident's continence status had not been assessed when he/she was admitted in July 2016. [s. 51. (2) (a)]

2. During stage one of the RQI, continence care triggered for an identified resident.

Record review of the identified resident's bladder continence assessments revealed that he/she had not been assessed using a clinically appropriate assessment instrument specifically designed for assessment of incontinence when his/her continence status changed in July 2015. The resident was admitted to the home a few months earlier.

Interview with RN #104 revealed that the identified resident should have been reassessed when his/her continence status changed in July 2015.
Interview with the DOC confirmed that the resident should have been assessed in July 2015, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when his/her continence status changed. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 provision of the care set out in the plan of care was documented.

During stage one of the RQI, Nutrition and Hydration triggered for an identified resident.

Record review of the identified resident's daily food and fluid intake record for the month

of November 2016, revealed that documentation for the morning nourishment pass had not been completed on November 1, 2, 3, 4, 5, 7, 9, 15, 16, 21, and 22, 2016.

Interview with personal support worker (PSW) #115 revealed that he/she had offered the identified resident the morning nourishment on November 1, 2, 4, 5, 15, 16, and 22, 2016, and had forgotten to document how much the resident drank on the above mentioned days.

Interview with PSW #118 revealed that he/she had offered the identified resident the morning nourishment on November 3 and 7, 2016, and did not document when the resident had refused the drink on the above mentioned days.

Interview with PSW #120 revealed that he/she had offered the identified resident the equivalent of two glasses of milk at the morning nourishment pass on November 9 and 21, 2016, and did not document the resident's fluid intake.

Interviews with RPN #101 and RN #116 revealed that it was the PSW's responsibility to document all residents' fluid intake at nourishment passes, and that PSWs #115, #118 and #120 should have completed the food and fluid intake record for the resident's intake on the above mentioned days.

The DOC confirmed that the identified resident's fluid intake at the morning nourishment pass on the above mentioned dates should have been completed on the resident's food and fluid intake record. [s. 6. (9)]

2. During stage one of the RQI, Nutrition and Hydration triggered for an identified resident.

Record review of the identified resident's daily food and fluid intake record for the month of November 2016, revealed that documentation for the morning nourishment pass had not been completed on November 1, 2, 3, 4, 5, 7, 9, 15, 16, 21 and 22, 2016.

Interview with PSW #115 revealed that he/she had offered the identified resident the morning nourishment on November 1, 2, 4, 5, 15, 16, and 22, 2016, and had forgotten to document how much the resident drank on the above mentioned days.

Interview with PSW #118 revealed that he/she had offered the identified resident the morning nourishment on November 3 and 7, 2016, and did not document when resident

had refused the drink on the above mentioned days.

Interview with PSW #120 revealed that he/she had offered the identified resident the morning nourishment on November 9 and 21, 2016, and did not document when the resident had refused the drink on the above mentioned days.

Interviews with RPN #101 and RN #116 revealed that it was the PSW's responsibility to document all residents' fluid intake at nourishment passes, and PSWs #115, #118 and #120 should have completed the food and fluid intake record for the identified resident’s intake on the above mentioned days.

The DOC confirmed that the identified resident’s fluid intake at the morning nourishment pass on the above mentioned dates should have been completed on the resident's food and fluid intake record. [s. 6. (9) 1.]

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 changed or care set out in the plan was no longer necessary.

During stage one of the RQI, minimizing restraints triggered for an identified resident. The inspector observed the resident's bed with two assist bed rails up while the resident was not in the bed.

Record review of the resident's most recent written plan of care did not mention the use of assist bed rails. Record review revealed consent for the use of two assist bed rails signed by the resident's daughter.

Interviews with the identified resident's daughter, PSW #102 and RN #104 revealed the identified resident used two assist bed rails while in bed for bed mobility. RN #104 revealed that a meeting was held with the care team and resident's daughter in November 2016, where the use of two assist bed rails was discussed and reviewed. PSWs #102 and #106 reported that the care plan should have been updated to reflect the identified resident's use of the bed rails. RN #104 stated that the resident's care plan should have been updated, when the resident's care needs changed, and somehow it was missed. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that they convened semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

Interview with the home's Executive Director confirmed that the home did not have an established Family Council in 2015, and did not convene semi-annual meetings to advise residents' families and persons of importance to residents, of their right to establish a Family Council in 2015. The home was unable to provide any supporting documentation of the same. [s. 59. (7) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During the RQI while conducting an observation of a medication administration pass, an identified resident was administered specified eye drops by RPN #101 on November 23, 2016, at the 0800 hours medication pass.

Record review of the identified resident's physician's orders revealed that on a specified date in November 2016, the resident had been prescribed eye drops, to be administered for five days.

Record review of the electronic medication administration record (e-MAR) revealed that the identified resident's eye drops should have been discontinued on November 22, 2016. The first dose of the eye drops was administered on November 17, 2016, at 2000 hours and last dose at 1600 hours on November 22, 2016.

Interview with RPN #101 revealed that the identified resident should not have been given the specified eye drops as the order had been discontinued the previous day.

Interview with the DOC confirmed that RPN #101 should have performed the medication administration rights prior to administering the eye drops to the identified resident, and followed the directions for use as specified by the prescriber.

2. During stage one of the RQI, nutrition and hydration triggered for an identified resident. While the inspector was conducting an observation of the identified resident on November 25, 2016, at 1425 hours, the inspector observed the feed infusing at a rate of 200ml/hour with less than 100ml of the specified feed in the bag to be infused.

Record review of the identified resident's November 2016 e-MAR indicated that the specified feed should infuse at a rate of 125ml/hour, and the water flush pre and post feed should be infused at 200ml/hour.

Interview with RPN #109 revealed that the identified resident's feed was running at an incorrect rate and immediately adjusted the rate to 125ml/hour.

The DOC confirmed that RPN #109 should have administered the feed to the identified resident at the rate specified by the prescriber. [s. 131. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

During stage one of the RQI on November 21, 2016, the inspector observed the following unlabeled items in a resident's shared bathroom in an identified room:
- One disposable razor
- One comb
- One bottle containing pink liquid.

Interview with RPN #100 revealed that all resident's personal belongings should be labeled to reduce the risk of infection transmission or cross contamination.

Interview with the DOC confirmed that resident's personal items in a shared bathroom should be labeled and kept at the resident's bed side to prevent the other resident from using the same items.

2. During the RQI while conducting an observation of a medication administration pass RPN #101 did not practice hand hygiene before preparing and administering medications, and in between administering eye drops, oral medications, and obtaining a glucometer reading for an identified resident.

The inspector observed that RPN #101 poured the identified resident's oral medications, then retrieved the eye drops and glucometer machine from the medication cart and proceeded to apply the gown and gloves for contact precautions before entering the resident's room. RPN #101 then administered two different eye drops, took the resident's glucometer reading, and administered oral medications without practicing any hand hygiene in between these activities. After completing the above mentioned tasks, RPN #101 removed the gown and gloves, and then performed hand hygiene.

Interview with RPN #101 revealed that he/she did not sanitize his/her hands prior to pouring the oral medications or at any time during the administration of the eye drops, oral medications, and obtaining a glucometer reading.

The DOC confirmed that RPN #101 should have cleaned his/her hands before pouring the identified resident's medications and during the different activities mentioned above. [s. 229. (4)]

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Issued on this 28th day of December, 2016

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

Original report signed by the inspector.