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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2017	2017_654605_0017	024510-17	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

SARAH KENNEDY (605), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 24, 25, 26, 27, 30, 31 and November 1 and 2, 2017.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed a resident medication administration, observed infection control practices, interviewed the Residents' Council (RC) President, interviewed the Family Council (FC) President, reviewed resident health records, meeting minutes, schedules, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Recreations Manager, registered nursing staff, Personal Support Workers (PSWs), President of the Residents' Council, residents and family members.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of medication administration, staff and resident interactions, provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, meeting minutes of Residents' and Family Council meetings, 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
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

5 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. (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 that there is a written plan of care for each resident that sets out the planned care for the resident.

During stage one of the Resident Quality Inspection (RQI), resident #005 triggered for inspection related to a medical condition.

Resident #005 was admitted to the home on an identified date. A review of the resident's electronic progress notes revealed the resident complained of a symptom on an identified date. The resident received a medical assessment on an identified date and was diagnosed with a medical condition. The resident was transferred to hospital and continued to complain of the identified symptom. Resident returned to the home.

A review of resident #005's written care plan revealed the medical symptom was not identified in the care plan.

Interviews with identified staff members revealed the resident was experiencing the symptoms when he/she returned from hospital.

An interview with the DOC confirmed the care plan should have been updated when resident #005 returned from hospital. [s. 6. (1) (a)]

2. During stage one of the RQI, resident #001 triggered for inspection related to a medical condition.

Resident #001 was admitted to the home on an identified date. A review of the resident's electronic progress notes revealed he/she sustained a fall which resulted in an injury. Resident received an intervention with varying effectiveness.

A review of resident #001's written plan of care revealed the identified medical symptom was not identified in the care plan.

Interviews with identified staff revealed the resident was experiencing the symptom when he/she returned from hospital and this was managed with interventions.

An interview with the DOC confirmed the care plan should have been updated to include the medical symptom when resident #001 returned from hospital. [s. 6. (1) (a)]

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

During stage one of the RQI, resident #008 triggered for inspection related to skin.

A review of the Resident Assessment Instrument Minimum Data System (RAI-MDS) from an identified date revealed resident #008 had an alteration in skin integrity.

A review of an assessment from an identified date revealed the resident had an alteration in skin integrity.

A review of the physician orders revealed an intervention to manage the alteration in skin integrity was ordered.

Observations revealed RPN #104 changed the treatment to the altered skin area. The treatment that was removed from the area was not the treatment prescribed in the written plan of care.

An interview with the RPN #108, who applied the treatment, revealed the treatment was not provided as ordered.

An interview with the DOC, who was present at the time of the interview with RPN #108,

confirmed the treatment was not the dressing prescribed in the written plan of care. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, 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 any policy put in place is complied with.

In accordance with Regulation, 48(1), paragraph 4, the licensee requires that a pain management program to identify pain in residents and manage pain is developed and implemented in the home.

A review of the homes "Pain Identification and Management Policy", updated February 2017, revealed residents are assessed for pain using the Pain Flow Note in PointClickCare (PCC) for a number of reasons including: on re-admission, if a resident states they have pain or if a resident is taking a new pain medication. The Pain Flow Note should be continued for 72 hours and is discontinued if pain is stable or meeting

needs for resident pain control. If a resident's pain is not being managed, a Pain Assessment will be completed.

During stage one of the RQI, resident #005 triggered for inspection due to increased pain.

Resident #005 was admitted to the home on an identified date. A review of the resident's electronic progress notes revealed the resident complained of pain on an identified date and a Pain Flow Note was completed. The resident received an intervention with varying effectiveness and following the complaint of pain, further Pain Flow Notes were not initiated.

The resident received an identified assessment on an identified date and he/she was diagnosed with an injury. The resident was transferred to hospital and complained of pain. Resident returned to the home on an identified date. Throughout this period of time no Pain Flow Notes were completed. Further review revealed a Pain Flow Note was not initiated until later, and this was not continued for a period of 72 hours.

A pain intervention was adjusted on an identified date. Following the change, Pain Flow Notes were also not completed for 72 hours.

An interview with resident #005 revealed he/she is not currently in pain, and if he/she experiences pain he/she notifies staff and receives assistance.

An interview with the DOC revealed resident #005 was not assessed for pain as per the homes "Pain Identification and Management" policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. During stage one of the RQI, resident #001 triggered for inspection related to increased pain.

Resident #001 was admitted to the home on an identified date. A review of the resident's electronic progress notes revealed he sustained a fall which resulted in injury. The resident returned from hospital on an identified date.

Record review revealed when resident #001 returned from hospital a Pain Flow Note was not initiated. Resident received a pain intervention with varying effectiveness. No other Pain Flow Notes were initiated. On an identified date, pain assessment was initiated, but not completed.

Inspector #605 was unable to interview resident #001 due to cognitive impairment; however, several observations revealed the resident appeared comfortable.

An interview with the DOC revealed resident #001 was not assessed for pain as per the homes "Pain Identification and Management" policy. [s. 8. (1) (a),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 any policy put in place is complied with, to be implemented voluntarily.

WN #3: 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 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.

During stage one of the RQI, resident #007 triggered for inspection due to an alteration in skin integrity.

A record review revealed the RAI-MDS from an identified date, revealed resident #007 had no areas of alteration in skin integrity identified on the assessment.

A review of the progress notes for a later identified date, revealed an alteration in skin integrity was identified. A skin assessment was completed but a referral was not sent to the RD.

An interview with RN #100 revealed on her review of resident #007's electronic record that a referral to the RD had not been sent once their was an alteration in skin integrity.

An interview with the DOC confirmed that it was the home's expectation that a referral to the RD be sent with any change in skin integrity and in this instance, following a review of resident #007's record, a referral to the RD had not been initiated. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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.

During stage one of the RQI, resident #008 triggered for inspection due to an alteration in skin integrity.

A review of the RAI-MDS from an identified date, revealed resident #008 had an alteration in skin integrity.

A review of the skin assessment for an identified date, revealed the resident had an alteration in skin integrity and no referral to the RD was made at this time.

An interview with RN #100 revealed an RD referral was not initiated for the altered skin integrity when there was a change. A referral was not initiated until a later date.

An interview with the DOC confirmed a referral was not made to the RD for resident #008

for the alteration in skin integrity, and it was the expectation of the home that a referral to the RD be made. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI, resident #007 triggered for inspection due to an alteration in skin integrity.

Resident #007 was admitted to the home on an identified date.

A record review revealed a skin assessment was completed on an identified date and an alteration in skin integrity was identified and a referral was sent to the Registered Dietitian (RD). No further skin assessments were initiated until a later date.

An interview with RN #100 revealed no further skin assessments were initiated.

An interview with the DOC revealed the expectation of the home is for skin assessments to be completed for resident's one week after identification of alteration in skin integrity, as clinically indicated. The DOC confirmed the resident had impaired skin integrity and another skin and wound assessment should have been completed on a weekly basis until resolved. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of inspection reports from the past two years are posted in the home.

During the initial tour of the home on October 24, 2017, inspector #513 observed one inspection report, #2016_382596_0017, was posted in the white Ministry of Health (MOH) binder at the unit entrance to the Long-term Care (LTC) unit second floor. This inspection report was placed in the MOH report section of the binder and was issued on December 15, 2016. There was no other inspection report observed at this time.

An interview with the DOC revealed that the binder on LTC unit second floor is the only location where the home posts inspection reports and it did not include inspection report # 2016_30610a_0002, issued on Jan 22, 2016. The DOC confirmed that it is the expectation of the home to post inspection reports from the past two years. [s. 79. (3) (k)]

WN #5: 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 used exclusively for drugs and drug-related supplies.

On an identified date, medication observations occurred on an identified unit in the home. Observations revealed the following items were in the locked narcotic box:

• An envelope
• A piece of jewelery belonging to an identified resident and
• Another piece of jewelery in a see-through biohazard bag belonging to an identified resident.

An interview with RPN #108 verified the identified items were stored in the narcotic box for safety reasons until family members could retrieve the items.

An interview with the DOC confirmed only medication and medication administration items were to be stored in the medication cart and the items previously noted were not to be stored in the narcotic box to ensure that the medication cart and narcotic box are only used for drugs and drug-related supplies. [s. 129. (1) (a)]

Issued on this 27th day of November, 2017

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

Original report signed by the inspector.