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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2015	2014_344586_0021	T-000051-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

LAKESHORE LODGE
3197 Lakeshore Blvd. West ETOBICOKE ON M8V 3X5

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

JESSICA PALADINO (586), LESLEY EDWARDS (506), THERESA MCMILLAN (526), VALERIE GOLDRUP (539)

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): December 22, 23, 29, 30, 2014 and January 5, 6, 7, 2015.

This inspection was conducted concurrently with Critical Incident Inspection T-000341-12, T-000206-14, T-000239-14, T-000691-14; and Complaint Inspection T-000489-13 and T-000787-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Manager of Resident Services, Manager of Building Services, Nurse Managers, Nutrition Manager, registered dietitian (RD), registered nursing staff, housekeeping staff, dietary staff, personal support workers (PSW's), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

7 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 written plan of care for each resident sets out clear directions to staff and others who provide direct care to the residents.

A) Resident #002's most recent quarterly nutrition review completed in December 2014 identified an ideal body weight (IBW) range of 48-59 kg, putting them at 98% of their IBW. The resident's written care plan identified that the resident's IBW range was 55-67

kg, indicating they were below their IBW at 85%. As the resident's IBW range was inconsistent, there was no clear direction for the staff related to the resident’s weight goals and required interventions.

B) Resident #004's most current written plan of care included a behaviour the resident exhibits regarding showers. The interventions provided by the registered staff on the written plan of care did not give clear direction to the PSW's in how to decrease the resident's behaviours in regards to showers. A member of the registered staff confirmed that the written plan of care should have been individualized to the resident. (539) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) On December 29, 2014 the written record of resident #004 was reviewed and the following was identified:

i. A Folstein Mini-Mental State Examination (MMSE) was completed with the resident on an identified date in January 2013. The resident’s score indicated moderate cognitive impairment. The resident Master Profile, which was kept with the written plan of care to direct staff, indicated that the resident had cognitive loss dementia and had a family member as a Substitute Decision Maker (SDM). As the SDM, they signed the consent for Levels of Intervention Plan of Care upon the resident's admission. On on an identified date in July 2013, staff at the home had the resident sign the Consent to Collect, Use and Disclose Personal Health Information Long-Term Care Homes and Services form, though there was no indication that the resident had been assessed as competent to provide informed consent. This was confirmed by a Nurse Manager.

ii. The resident's most current written plan of care (updated on an identified date in October 2014) stated that the resident will not resist care. The goal stated that the resident will not exhibit the behaviour and will verbalize feelings/reasons behind the behaviour; however, the Master Profile (last updated on an identified date in July 2014) under the communication section, noted that the resident was only "sometimes understood - ability is limited to making concrete requests". This was confirmed with a Nurse Manager.

iii. An MMSE was completed by the Social Worker with the resident on an identified date in September 2014. The resident’s scored indicated severe cognitive impairment. A care conference then took place on an identified date in September 2014. The resident Master Profile was last updated on an identified date in July 2014 and did not reflect the most recent assessments. A member of the registered staff confirmed that the Master Profile should have been updated on an identified date in October 2014 when the written plan of care was updated.

iv. A Resident Assessment Protocol (RAP) Summary, completed on an identified date in October 2014, stated that the resident refused to shower or change their gown at night. The written care plan did not reflect that the resident refused to change their gown at night. A Nurse Manager confirmed that the resident had improved with interventions being put in place and confirmed the written care plan should have been individualized, updated and reflect all behaviours and interventions needed to address the resident's care needs.

v. An update was made to the written plan of care by the RD on an identified date in December 2014. This was found in the electronic system but not in the printed care plan on the unit. A member of the registered staff confirmed that it was the expectation of the home that the staff member would print and place the updated version in the binder for access by the staff on the unit.

B) On January 4, 2015 the written record of resident #010 was reviewed and the following was found:
i. Resident #010's written plan of care regarding physical restraints last updated on an identified date in November 2014 stated that the resident had two quarter bed rails. Progress notes from an identified date in May 2014 demonstrated a referral was made to the Occupational Therapist (OT) "to address the resident's needs for bedside quarter rails". A master checklist was completed; however, no further written documentation could be found regarding an individual bed rails assessment by the OT. This was confirmed with the Manager of Resident Services and two Nurse Managers.

ii. Resident #010's written plan of care regarding physical restraints last updated on an identified date in November 2014 stated that the resident had two quarter bed rails. A Nurse Manager confirmed that nursing had also reviewed the need for the quarter side rails in May 2014. They confirmed the quarter side rails were not considered a restraint and should not have been noted as a restraint under the written plan of care, as well as that the plan of care should have been updated to reflect that the resident required bed

rails as a Personal Assistance Services Device (PASD).

C) On January 6, 2015 the written record of resident #002 was reviewed and the following was found:

i. Resident # 002 was assessed by an OT on an identified date in November 2014 regarding positioning in their tilt wheelchair. The OT recommended that when the resident is in their wheelchair, the tilt mechanism was to be used and that the chair be tilted "20 – 30 degrees for pressure relief". The written plan of care (last updated on an identified date in December 2014) did not include the specific directions to staff. A member of the registered staff confirmed that the plan of care had not been updated to reflect the specific recommendations and direction to the PSW's who position the resident. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in resident #009's plan of care was provided as per the plan.

A) Resident #009's documented care plan and diet list identified that the resident was to receive 125 ml of a particular beverage at lunch and dinner. Observation of the lunch meal services on December 29 and 30, 2014 revealed that the resident did not receive the intervention as identified in their care plan. Interview with the individual feeding the resident on December 30, 2014 confirmed that if the resident was not drinking much of their other fluids, they would request the beverage from the kitchen. The care set out in the resident's plan of care was not provided to the resident as per the plan.

B) During an interview by Inspector #526 on December 23, 2014, a family member of resident #009 stated that the resident was always being fully fed.

i. Review of resident #009's plan of care identified that during mealtime, staff were to allow the resident to self-feed, and if the resident were unable to do so, for staff to provide extensive assistance as needed but to ensure the resident participates.
ii. Observation of the lunch meal service on December 29 and 30, 2014 revealed that the resident was being fully fed by their personal companion, and was not observed to be encouraged to feed themselves.
iii. Interview with the companion on December 30, 2014 confirmed that the resident at times could hold a spoon; however, when doing so are very shaky and eats quite slowly, so the companion typically fully feeds the resident.
iv. Review of the home's Companion Policy identified that when a companion is hired into

the home by a family, a "Sitter/Companion Acknowledgement" form is to be filled out and signed by the companion, which includes agreement to complying with the home's policies related to resident care.
Documentation revealed this form was signed by resident #009's companion on an identified date in September 2014
v. Interview with a Nurse Manager and the DOC on December 30, 2014 confirmed that the home is responsible for the care provided to all of the residents, even by a companion, and that it was ultimately the home's responsibility to ensure every companion was aware of and following the residents' plans of care. [s. 6. (7)]

4. The licensee has failed to ensure that resident #008's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #008's documented care plan indicated under the ADL Assistance section that the resident should be repositioned in their wheelchair hourly while they were in their chair. The Impaired Mobility/Positioning/Repositioning in Broda Chair section of the resident's documented care plan indicated that the resident should be repositioned every two hours while in their Broda chair. Interview with registered staff revealed the resident no longer used a wheelchair and only used a Broda chair. This was confirmed by a Nurse Manager, who also confirmed that the care plan should have been revised to remove the use of a wheelchair. The resident's plan of care was not revised when care set out in the plan was no longer necessary.

B) Resident #008 had a pressure area on their body on December 15, 2014. Record review and interview with the DOC on January 12, 2015 confirmed that the wound had healed and the resident did not have any pressure areas currently. As of January 12, 2015, the resident's most updated documented care plan still indicated that the resident had a pressure area present. Interview with the DOC confirmed the plan of care should have been revised as the care set out in the plan was no longer necessary. [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 all residents' written plans of care sets out clear directions to staff and others who provide direct care to the residents; to ensure staff and others involved in the different aspects of care of the residents collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; to ensure the care set out in every residents' plan of care is provided as per the plan; and to ensure every resident's plan of care is reviewed and revised when their care needs change or the 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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's significant weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Review of resident #002's weight records on December 30, 2014 revealed that the resident experienced a significant weight loss over three months between June and September 2014.

i. Progress notes demonstrated that the resident was assessed by the RD on an identified date in September 2014 for severe weight loss. The RD initiated a three-day meal intake to review the resident's oral intake.
ii. Review of the resident's health records and interview with the Nutrition Manager and wound care nurse confirmed that after the three-day meal intake was completed, there was no follow-up completed by the RD and the outcomes of the three day meal intake were not evaluated. The resident was not reassessed by the RD until their quarterly assessment on an identified date in October 2014, whereby no interventions were put into place.
iii. The resident developed a pressure area on their body in October 2014.
iv. Review of the resident's most recent documented care plan (last updated on an identified date in October 2014) and diet list, as well as interview with the Nutrition Manager, revealed there were no actions taken or interventions put into place to manage the resident's significant weight loss or new pressure area.
v. The resident continued to lose further weight after the RD's initial assessment in September 2014 and the quarterly review in October 2014. The resident's most recent December 2014 weight indicated further weight loss.
vi. The resident's next quarterly nutrition review was completed for December 2014 and it indicated the resident had a pressure area on their body and that they were just below their ideal weight range; however, no changes were to be made to any interventions. This was confirmed by the Nutrition Manager. [s. 69. 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 all residents who experiences significant weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #3: 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 were stored in an area or a medication cart that was secure and locked.

A) On December 22, 2014, while in the resident computer room completing a resident interview, the inspector observed a nurse enter a resident's room to administer medication. The medication cart was noted to be left unlocked and unattended while the nurse went into the room to administer the medication. A resident was observed to pass by the cart in their wheelchair to enter the adjacent room while the staff member was absent.

B) On December 30, 2014 the medication cart was left unattended and unlocked at the nurse's station. The doors leading into the nurse's station were left open and accessible to anyone. The inspector was able to open all the drawers of the medication cart and the registered staff did not return to the medication cart for greater than ten minutes. The inspector then approached the Nurse Manager who confirmed that the medication cart was not to be left opened and then proceeded to lock the medication cart. (506) [s. 129. (1)

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 drugs are stored in an area or a medication care that is secure and locked, to be implemented voluntarily.

WN #4: 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 resident #009's room was kept clean and sanitary.

During an interview by Inspector #526 on December 23, 2014, a family member of resident #009 voiced concern that the resident's floor did not always appear to be clean. During observation of the resident's room on December 29, 2014, it was noted that a potted plant had been tipped over and there was a large amount of dirt and leaves that had fallen onto the resident's floor. The room was observed again the following day on December 30, 2014 and it was noted that part of the mess had been cleaned; however, there was still a visibly large amount of dirt and leaves on the floor. Interview with the housekeeping staff on the unit confirmed that all resident rooms on that floor had been cleaned that day. [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #010 had two bed rails in place. A review of the bed assessment procedure with the Manager of Building Services and the maintenance staff confirmed that a biannual audit was completed internally on the beds. The home's policy "Bed System Safety" (dated October 01, 2014) identified the seven signs of entrapment and stated that the audit occur with a "vendor and be signed by the Building Service Manager". The staff confirmed that the no external provider had been hired to complete an assessment of the bed zones of entrapment using a standardized tool and assessment process. [s. 15. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Review of resident #008's progress notes revealed that on an identified date in December 2014, the resident had a pressure area discovered on their body. After this initial progress note, there was no further documentation in the progress notes regarding the status of the resident's wound, any wound care provided to the resident, or any information informing staff that the wound had healed. When interviewed on January 5, 2015, after reviewing the resident's health care record, the unit's RN and Nurse Manager both stated that they were unaware of any recent wounds on the resident's buttocks. Telephone interview with the DOC on January 12, 2015 confirmed that the status of the resident's wound and responses to the interventions should have been documented in the progress notes. [s. 30. (2)]

WN #7: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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 has failed to ensure that fluids are being served at a temperature that is both safe and palatable to the residents.

The home's Temperature Record form indicated that cold drinks were to be maintained at a maximum temperature of 40°F/4.4°C. During lunch dining service on January 6, 2015, four empty meal trays were observed at the servery awaiting plating and delivery to residents in their rooms after the dining service concluded as confirmed by the Nutrition Manager. At 1200 hours there were three pre-poured glasses of milk and one labelled high protein drink on the trays. The drinks were observed sitting on the trays beside the hot steam table until 1230 hours when the inspector brought this to the Nutrition Manager's attention. The milk was probed at a temperature of 12.5°C. The Nutrition Manager confirmed the temperatures were above the acceptable range. [s. 73. (1) 6.]

2. The licensee has failed to ensure proper techniques were used to assist resident #009 with eating, including safe positioning.

On an identified date in December 2014 resident #009 was eating lunch in bed with the total assistance with feeding. The inspector was sitting at the nursing station just outside the resident's room and heard two separate instances of the resident coughing while being fed.

i. The resident's plan of care identified that during meal time, the resident's head is to be positioned for safe swallowing and for them to sit in an upright position.
ii. When the inspector entered the room, it was observed that the resident's bed was not at a 90 degree angle. The inspector suggested to the companion that the head of the resident's bed be elevated to 90 degrees; however, the companion stated that it is typical for the resident to cough a few times while eating, and did not elevate the resident's bed. The inspector immediately informed the home of the occurrence. Interview with the DOC confirmed residents should be seated at a 90 degree angle while eating.
iii. Review of the home's Companion Policy identified that when a companion is hired into the home by a family, a "Sitter/Companion Acknowledgement" form is to be filled out and signed by the companion, which includes agreement to complying with the home's policies related to resident care, confidentiality and safety at all times. Documentation revealed this form was signed by resident #009's companion on an identified date in September 2014.
iv. Interview with a Nurse Manager and the DOC on December 30, 2014 about the occurrence confirmed that every companion is trained by the home on their policies and procedures. They also confirmed that the home is responsible for the care provided to all of the residents, even by a companion, and that it was ultimately the home's responsibility to ensure every companion was aware of and followed the residents' plans

of care. [s. 73. (1) 10.]

Issued on this 9th day of February, 2015

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

Original report signed by the inspector.