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
Sep 23, 2014	2014_171155_0022	L-001202-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street, MARKDALE, ON, N0C-1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH, MARKDALE, ON, N0C-1H0

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

SHARON PERRY (155), MARIAN MACDONALD (137), SHERRI GROULX (519)

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): September 8, 9, 10, 11, 12, 15, 16 and 17, 2014.

Two critical incident inspections (001323-14 and 002207-14) and one complaint inspection (003494-14) were done concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care, Nutrition and Environmental Services Manager, Maintenance Manager, Resident and Family Services Manager, Office Manager, Social Worker, Director of Long Term Care, 2 Registered Nurses, 5 Registered Practical Nurses, 10 Personal Support Workers, Laundry Aide, Cook, 2 Dietary Aides, 2 Environmental Services Workers, 2 Recreation Assistants, Resident Council representative, Family Council representative, 4 Family Members and 40+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of all Resident Living Areas, common areas, dining rooms, kitchen, laundry room, and 2 medication rooms; observed resident care provision, resident-staff interactions, dining service, recreational activities, and medication administration; reviewed relevant residents' clinical records, posting of required information, relevant polices and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
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 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 11. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

Observations, throughout the RQI, revealed:

(a) During two dining observations, the e-MAR terminal was unlocked and unattended, with residents' Personal Health Information (PHI) accessible. The Registered Staff member was administering medications in the dining room and the medication cart was not in visual proximity.

The Registered Staff members confirmed the e-MAR terminal was unlocked, with Personal Health Information (PHI) accessible, as well as the expectation is the e-MAR terminal be locked when the medication cart is not attended.(137)

(b) On September 8, 2014 at 12:50 pm, during a dining observation, the residents' seating plan was posted on the bulletin board. The seating plan contained Personal Health Information (PHI) such as diets, textures, likes/dislikes and the information was accessible to residents and visitors.

A dietary aide confirmed the seating plan was posted.
The Administrator shared consent was not obtained and the seating plan should not have been posted, allowing access to PHI.(137)

(c) On September 10, 2014 at 11:18 am, a chart room door was observed propped open, with access available to residents' clinical records and PHI. There were no staff members in attendance.

A registered nurse confirmed the door was open, with access available to residents' clinical records and PHI, as well as the expectation the door be locked when no staff members are in attendance.
The Administrator confirmed the expectation is that the chart room doors be kept locked when no staff members are in attendance, to ensure each resident's Personal Health Information is protected.(137)

(d) During two observations of the noon medication passes that the registered staff were discarding the medication strip packages after drug administration into the regular garbage. Registered staff confirmed that the pouches go in the regular garbage. The Director of the Resident Care confirmed that the medication strip packages contained resident's personal health information and that they should not be placed in the regular garbage.(155) [s. 3. (1) 11. 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 every resident has the right to have his or her personal health information within the meaning of the Personal health Information Protection Act, 2004 kept confidential in accordance with the Act, to be implemented voluntarily.

WN #2: 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.

Observations, throughout the RQI, revealed the following in identified rooms:

(a) Flooring under the bathroom sink is water stained and damaged. Bathroom wall and wooden bedroom door are damaged.
(b) Bathroom wall damaged and flooring is water stained.
(c) Flooring under bathroom sink is water stained and in disrepair. Bathroom wall is damaged.
(d) Paint and minor wall damage at left of the entrance door.
(e) Bathroom wall damaged. Baseboard damaged to the left of the bathroom door entrance.
(f) Hole in bathroom floor at base of toilet and bathroom wall damaged.
(g) Wooden bathroom door chipped. Bathroom wall chipped and scraped. Hole in bathroom flooring and water stained.
(h) Flooring is cracked at the seam between the foot of the beds. Bathroom flooring cracked at base of toilet and counter top press board exposed at edging.
(i) Bathroom flooring is water stained and counter top press board exposed.
(j) Finish off 10/10 (100%) dining room chairs.
(k) Shower Room – floor drain dirty and yellow, slimy debris present. Tub dripping. Registers damaged.
(l) Emergency Eye Wash Room – flooring is cracked around toilet. Counter top press board exposed.
(m) Duct tape on seam of bathroom floor in front of the toilet.
(n) Bathroom flooring water stained under sink and at base of toilet.
(o) Bathroom walls damaged.
(p) Bathroom wall damaged to the right of the entrance and above bathroom sink.
(q) Bathroom walls and wooden bedroom door are damaged.
(r) Bedroom wall damaged to the left of the bathroom door entrance. Scrapes on bedroom wall, to the left of the bed.
(s) Bedroom wall damaged behind the entrance door to the room.
(t) Lower section of bedroom wall damaged, to the right of the room entrance.

During a tour of the home, Maintenance Manager confirmed the identified deficiencies and the expectation is the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

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

Observations, throughout the RQI, revealed:

a) On September 9, 2014 at 1:59 pm and September 16, 2014 at 10:15 am in an identified room, two wash basins were stored on the bathroom floor behind the toilet.
b) On September 9, 2014 at 1:47 pm and September 16, 2014 at 10:15 am in an identified room, a white urine measuring hat was stored on the back of the toilet.
c) On September 16, 2014 at 10:20 am in an identified room, an unlabelled toothbrush was on the bathroom counter in a shared washroom.
d) On September 16, 2014 at 10:25 am in an identified room, an unlabelled denture cup, containing 2 bars of used soap, was on the bathroom counter in a shared washroom.
e) On September 16, 2014 at 10:35 am in a tub room, one unlabelled grey comb was

on the linen cart and one unlabelled wash basin was stored on the floor at the back of the tub.
f) On September 16, 2014 at 10:30 am in a tub room, one unlabelled pink comb was stored in a black plastic container on the shelf and the padding is cracked on the shower chair, exposing the seating foam.
g) During three dining observations in two dining rooms, five (5) different staff members served meals/desserts to residents after clearing soiled dishes, without utilizing hand hygiene measures, such as hand washing or hand sanitizer.

An interview with the Director of Care confirmed there is no policy for the storage of personal care items and shared the expectation is that all personal care items should be labelled and stored in the resident's bedside table or cupboard.
The Director of Care also confirmed there is a hand hygiene program in place and the expectation is all staff are to utilize hand hygiene measures before serving meals/desserts to residents, after clearing soiled dishes. [s. 229. (4)]

2. The licensee failed to ensure staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of three employee files revealed there was no documented evidence that two of three (66%) employees were screened for tuberculosis prior to commencing employment.

The Director of Care confirmed the employees were not screened, the home's policy was not complied with and the expectation is all employees are to be screened for tuberculosis prior to commencing employment. [s. 229. (10) 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 participate in the implementation of the program, and that staff are screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During a clinical record review and staff interviews, it was revealed an identified resident has responsive behaviours. There is no documented evidence of responsive behaviours on the plan of care, as well as interventions to address behaviours.
A Registered Staff member confirmed responsive behaviours were not identified on the plan of care and the plan of care did not give clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On September 8, 2014, observations revealed six (6) windows opened beyond the legislative requirement of 15 centimetres and one window was missing a screen.

The Administrator confirmed the expectation is that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. [s. 16.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On September 8, 2014 at 12:25 pm, during the dining observation, the medication cart was unlocked and unattended. The Registered Staff member was administering medications in the dining room and the medication cart was not in visual proximity. The Registered Staff member confirmed that the medication cart was unlocked and unattended as well as the expectation is that the medication cart is locked when unattended. [s. 129. (1) (a)]

Issued on this 24th day of September, 2014

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

SHARON PERRY