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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2018	2018_560632_0016	017799-18	Resident Quality Inspection

Licensee/Titulaire de permis

Bella Senior Care Residences Inc.
650 Sheppard Avenue East PH01 TORONTO ON M2K 3E4

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

Bella Senior Care Residences
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

YULIYA FEDOTOVA (632), CATHY FEDIASH (214), DARIA TRZOS (561), ROSEANNE WESTERN (508)

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): July 19, 20, 23, 24, 26, 27, 30, 31, August 1, 2, 3, 7, 8, 9, 10, 13, 14, 15, 16, 2018

The following Follow Up (FU) inspections were completed concurrently with this RQI:
Log #009910-18 was related to bathing
Log #009911-18 was related to continence
Log #008321-18 was related to continence

The following complaint inspections were completed concurrently with this RQI:
Log #015333-18 was related to hospitalization and change in a condition
Log #013325-18 was related to staffing, continence, bathing and personal support services

The following reported Critical Incident System (CIS) inspections were completed concurrently with this RQI:
Log #013904-18 was related to medication
Log #016518-18 was related to falls prevention
Log #016418-18 was related to falls prevention
Log #008925-18 was related to falls prevention
Log #011668-18 was related to nutrition and hydration

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Co-ordinator, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Registered Dietitian, the Restorative, the Maintenance Supervisor, the Assistant Environmental Services Supervisor, the Nursing Unit Clerk Manager, the Residents Support Service Manager, the Social Worker and Admission Co-ordinator, residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including residents' rooms and common areas, reviewed infection prevention and control policy, reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, staff files, observed the provision of care and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 51. (2)	CO #002	2018_569508_0004	561
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2018_569508_0004	561
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_569508_0006	561

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. On identified dates in July 2018, the specified devices for resident #003 were observed in an identified position. On an identified date in July 2018, resident #003 indicated that they did not use the specified device, while in a bed. On an identified date in July 2018, Personal Support Worker (PSW) #125 also indicated that resident #003 did not use the specified device. Review of the written plan of care (date initiated on an identified date in June 2018) indicated in written plan of care that specified devices secured down with ties. Secured to bed". On an identified date in July 2018, the statement in the resident's written plan of care was interpreted to Inspector #632 by PSW #125 as specified devices stayed up and not used as restraint. On an identified date in August 2018, Registered Practical Nurse (RPN) #110 interpreted to Inspector #632 the same section as "down below the level of the bed. Down means down" and PSW #129 interpreted the same section as the specified devices would come down below the level

of the bed and staff were to adjust and to secure them that they would not be wobbly". On an identified date in August 2018, the Administrator acknowledged that the directions for staff who provided care for resident #003 were not clear.

The licensee failed to ensure that there was a written plan of care for resident #003 that sets out clear directions to staff who provided direct care to the resident.

B. A review of a Critical Incident System (CIS) Report #2890-000012-18, indicated that on an identified date in April 2018, at 1800 hours, resident #004 had an incident. The CIS Report indicated that the resident was transferred to hospital the same day. A review of a progress note dated on an identified date in April 2018, indicated that the resident's family member had informed the long-term care (LTC) facility that the resident had sustained an injury.

A review of the resident's current electronic care plan, indicated under interventions for the prevention of incidents, with a created identified date in June 2018, that staff would follow universal precautions to prevent the incidents.

An interview on an identified date in August 2018, with full time PSW #113 and PSW #135, who both worked on the same unit as the resident resided, indicated that they did not know what the intervention referred to. An interview with registered RPN #138 on an identified date in August 2018, and the author of the intervention indicated that this intervention was a "drop down" option to choose in the Point Click Care (PCC) library. An interview with the Administrator, the DOC and registered RPN #138, on an identified date in August 2018, confirmed that the written plan of care for resident #004, in relation to the incidents had not set out clear directions to staff and others who provided direct care to the resident.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection log#008925-18, conducted concurrently during the RQI.

C. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of a CIS report #2890-000018-18, indicated that on an identified date in July 2018, resident #014 had an incident. The CIS indicated that the incident was unwitnessed.

A review of a progress note dated on an identified date in July 2018, indicated that the resident was assessed. The resident's Power of Attorney (POA), was made aware of the incident and declined transfer to the hospital at this time and would consider a transfer to hospital if the resident was showing identified signs. A progress note dated on an identified date in July 2018, indicated that the resident was assessed on an identified date in July 2018, as having identified signs. The resident's identified sites with the identified signs. Resident's family was notified and the resident was transferred to hospital. A progress note dated on an identified date in July 2018, indicated that the hospital called and notified the LTC facility that the resident had sustained an identified injury and upon assessment and discussion with an identified medical specialist, it was determined that the resident had an identified risk. The POA made the decision to send the resident back to the LTC facility with identified measures in place.

A review of the resident's clinical records indicated that admission information from the identified centre on a form dated on an identified date in April 2018, indicated that the resident was coded as having not had any incidents in the last 90 days and a document completed by the identified centre dated on an identified date in April 2018, indicated that the resident had not had a potential problem related to the incidents. A review of the resident's clinical records indicated that the resident had been admitted to the long-term care facility on an identified date in June 2018, and had no history of the incidents since their admission.

A review of a significant change in status Minimum Data Set (MDS) narrative RAP dated on an identified date in July 2018, indicated that the resident was assessed to be at identified risk for the incidents. A review of the resident's current electronic care plan with a created date on an identified date in July 2018, indicated that the resident was to have an identified intervention that staff would follow identified precautions to prevent the incidents, which was created on an identified date in June 2018.

An interview with RPN #138 on an identified date in August 2018, and the author of the intervention indicated that this intervention was a "drop down" option to choose in the PCC library. An interview with the DOC and RPN #138, on an identified date in August 2018, confirmed that the written plan of care for resident #014, in relation to the incidents had not set out clear directions to staff and others who provided direct care to the resident.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #016418-18, conducted concurrently during the Resident Quality Inspection (RQI). [s. 6.

(1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

On identified dates in July 2018, resident #002's bed was observed having specified devices in an identified position. On an identified date in August 2018, resident #002 indicated that they used specified devices. On an identified date in August 2018, PSW #131 indicated that the resident used the specified devices. Review of the most current written care plan, initiated on an identified date in May 2018, indicated that one staff to provide identified assistance to the resident and the resident to hold onto the specified devices to assist themselves with positioning. Review of the most recent identified assessment with the locked date on an identified date in May 2018, indicated that the resident required assistance with the specified devices with mobility and it also indicated that specified devices were removed on both sides. On an identified date in August 2018, RPN #130 confirmed that the written plan of care was not based on the most recent identified assessment of the resident, which was acknowledged by the Administrator on the same date.

The licensee failed to ensure that the plan of care was for resident #002 based on the identified assessment of the resident and the resident's needs and preferences to have specified devices in place. [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of a CIS Report #2890-000018-18, indicated that on an identified date in July 2018, resident #014 was found by staff in identified location of the home. The CIS indicated that the incident was unwitnessed.

A review of a progress note dated on an identified date in July 2018, indicated that the resident was assessed. The resident's POA was made aware of the fall and declined transfer to the hospital at this time and would consider a transfer to hospital if the resident was showing identified signs. A progress note dated on an identified date in July 2018, indicated that the resident was assessed on an identified date in July 2018, to be expressing identified signs. The resident's body sites showed identified signs of

injury. Resident's family was notified and the resident was transferred to hospital. A progress note dated on an identified date in July 2018, indicated that the hospital called and notified the LTC facility that the resident had sustained an identified injury and upon assessment and discussion with an identified medical specialist, it was determined that the resident was a high risk for the intervention. The POA made the decision to send the resident back to the LTC facility with identified measures only in place. A progress note dated on an identified date in July 2018, indicated that the resident returned from the hospital to the LTC facility.

MDS assessment, completed upon the resident's return back to the LTC facility and dated on an identified date in July 2018, indicated that the resident had been coded as having had an incident in the past 30 days; an identified injury in the last 180 days; other identified injuries in the last 180 days and the corresponding narrative Resident Assessment Protocol (RAP), dated on an identified date in July 2018, indicated that the resident was a high risk for the incidents. A review of an assessment in PCC (dated on an identified date in July 2018) indicated that the resident was a low risk for the incidents. This assessment contained an area to check if the resident made attempts to unsafely move due to identified symptoms. This area was observed to not have been checked off. An interview on an identified date in August 2018, with RPN #133, author of the assessment and the RAI Co-ordinator, was conducted. RPN #133 confirmed that this area on the incidents' Risk Screen should have been checked off and the resident identified as a high incident risk. RPN #133 confirmed that the MDS coding and assessment protocol were accurate and that they had not collaborated in the assessment of resident #014 with other direct care staff so that their assessments were integrated, consistent and complemented each other.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection log#016418-18 conducted concurrently during the RQI. [s. 6. (4) (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 and ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, the plan of care was based on an assessment of the resident and the resident's needs and preferences, and the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 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 were documented.

A) Resident #009 was scheduled for two specific interventions per week. On an identified date in August 2018, the resident's clinical records were reviewed for an identified number of days during look back period specifically related to the resident's specific interventions.

Review of these records indicated that the resident received only two specific interventions on an identified dates in July 2018 and in August 2018. The Resident Assessment Instrument (RAI) Co-ordinator indicated that the resident was not receiving specific interventions during this look back period as the resident had identified

interventions in place and were only receiving other specific interventions during this time.

The resident's clinical record provided an option for staff to document when other specific interventions were provided for residents; however, staff did not document this information. An interview with resident #009 confirmed that staff were providing other specific interventions during this time.

It was confirmed during an interview with the RAI Co-ordinator on an identified date in August 2018, that staff did not document actions taken with respect to a resident.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection log #013325-18 conducted concurrently during the Resident Quality Inspection (RQI).

B) Resident #021 was scheduled for two specific intervention per week. On an identified date in August 2018, the resident's clinical records were reviewed for an identified number of days during the look back period specifically related to the resident's specific interventions.

Review of these records indicated that the resident received only two specific interventions on identified dates in July 2018 and in August 2018. The RAI Co-ordinator indicated that the resident would regularly refuse their specific interventions. This was also confirmed during review of the resident's plan of care.

The resident's clinical record provided an option for staff to document, when residents would refuse their specific interventions; however, staff did not document that the resident had refused them.

It was confirmed during an interview with the RAI Co-ordinator on an identified date in August 2018, that staff did not document actions taken with respect to a resident.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection log#013325-18 conducted concurrently during the RQI. [s. 30. (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 and ensuring 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with the resident #012 on an identified date in July 2018, the resident indicated that they were not offered a specific intervention but only other specific interventions.The resident stated that they did prefer to have a specific intervention.

PSW #111 confirmed that they were not using the specified equipment for any of the residents as there were currently no residents, who requested a specified equipment. PSW #111 stated they did not know if the specified equipment was working or not.

Interview with the DOC on an identified date in July 2018, confirmed that the specified equipment was not working properly; however, this had not been brought to their attention until the LTC Homes Inspector asked the DOC about this. It was also not documented in the maintenance log book and the maintenance department was also unaware.

It was confirmed on an identified date in July 2018, during interviews that resident #012 was not being offered specific intervention, which was the resident's preference. [s. 33. (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 and ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: 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 failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A review of the resident's clinical record indicated that the resident had an unwitnessed incident on an identified date in May 2018. The resident was assessed by the registered staff; however, resident did not complain of identified signs in their identified sites until identified date in May 2018. The Physician ordered an identified intervention to be obtained at the home and in identified amount of days it was confirmed through the identified intervention that the resident sustained identified injury.

The resident had identified intervention on an identified date in May 2018, and returned back to the home on an identified date in June 2018, with an identified interventions on their identified site of the body. A review of the resident's identified assessment completed on an identified date in June 2018, indicated that the resident had an identified skin condition from the specified devices. A treatment was ordered on an identified date in June 2018 and the identified interventions were ordered for the identified number of days.

During a review by the Physician of the resident's identified clinical records it was identified that the resident's identified interventions continued to be done up until an identified date in July 2018. At this time the order was discontinued as the identified skin condition had changed. Review of the resident's clinical records indicated that the treatments had been completed for identified number of days; however, an identified assessment using a clinically appropriate assessment instrument had only been completed for this identified skin condition on an identified date in June 2018.

It was confirmed during an interview with RAI Co-ordinator #102 and through documentation review that the identified skin condition had not been assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for identified skin condition assessment. [s. 50. (2) (b) (i)]

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 and ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the hydration program included the implementation of interventions to mitigate and manage residents with identified risks related to hydration.

Complaint log #015333-18 was submitted to the MOHLTC on an identified date in June 2018, related to the plan of care for resident #016. Review of resident #016 written plan of care, initiated on an identified date in June 2108, included in identified interventions section identified hydration restrictions per day for the resident. Review of resident #016's identified intake for the period of identified dates in June 2018, indicated that the resident consumed identified amount of fluids per day and for the period of identified dates in June 2018, the resident also consumed identified amount of fluids per day. On an identified date in August 2018, RN#154 indicated that for all residents in the home daily identified intakes were included in the identified report, which was printed out by the night shift registered staff and reviewed by the day shift registered staff. RN #154 indicated that daily summary of identified intakes for those residents, who were below the identified needs for the identified intake, were highlighted by the program in red and those residents, who met or exceeded the identified target needs - were not flagged. On an identified date in August 2018, the DOC indicated that the electronic reports for monitoring identified intakes among the residents were focused on identified risks and did not capture other identified risks.

The home failed to ensure that the identified program included the implementation of interventions to mitigate other identified risks for residents, who had identified interventions.

PLEASE NOTE: This area of non-compliance was identified during complaint inspection log#015333-18 conducted concurrently during the RQI. [s. 68. (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 and ensuring that hydration program includes the implementation of interventions to mitigate the fluid intake of residents with identified risks related to hydration, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee failed to ensure that all the persons hired on or after January 1, 2016 as personal support workers or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements listed below and had provided the licensee with proof of graduation issued by the education provider.

The licensee failed to ensure that all staff of the home had the proper skills and qualifications to perform their duties.

Under the LTC Home Act, 2007, "staff" was defined as:
"staff", in relation to a long-term care home, meant persons who worked at the home,

(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

The home had a contract agreement dated on an identified date in December, 2016, with an identified agency, who supplied PSWs and registered staff to the home, when the home could not fill shifts with employees employed by the home.

A concern was brought forth related to agency staff that had been working in the home, who did not have the skills and qualifications to perform their duties, specifically, toileting and bathing residents.

During this inspection, on an identified date in August 2018, the LTC Homes Inspector

requested personnel files of the identified agency's PSW staff, who worked regularly in the home to confirm their qualifications. The home did not have copies of these files as the agency had failed to provide them. On an identified date in August 2018, the LTC Homes Inspector contacted the agency and requested these files.

The identified agency provided some of the employee's credentials; however, did not provide the qualifications of PSW #136, who had worked regularly in the home as a PSW. During an interview with the DOC on an identified date in August 2018, it was confirmed that the home had not verified the agency staff's qualifications as the agency had not provided them to the home.

A review of the PSW staffing schedule from an identified date in June to an identified date in July 2018, indicated that staff #136 worked on identified dates in June and July 2018.

On an identified date in August 2018, the DOC and the Administrator confirmed that they had attempted to obtain the credentials and qualifications of PSW #136 from the agency but were unsuccessful and could not provide documentation to this LTC Homes Inspector to ensure that all staff of the home had the proper skills and qualifications to perform their duties.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection log #013325-18 conducted concurrently during this RQI. [s. 73. (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 and ensuring that all the persons hired on or after January 1, 2016 as personal support workers or to provide personal support services, regardless of title, have successfully completed a personal support worker program that met the requirements listed below and have provided the licensee with proof of graduation issued by the education provider, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device used to restrain a resident was applied in accordance with the manufacturer's instructions.

The identified manufacturer's instruction stated to apply a specified device in identified manner. Resident #008 was observed in identified home area in their mobility device by LTC Homes Inspector #632 during stage one of the inspection, on an identified date in July 2018. Their specified device was observed in an identified application. On an identified date in July 2018, staff #106 indicated that the specified device was applied in an identified manner. PSW #106 was able to apply the specified device correctly on the resident once incorrect application was noted. On an identified date in July 2018, LTC Homes Inspector #632 observed resident #008 in identified home area in their mobility device and their specified device was observed to be applied in identified manner. On an identified date in July 2018, RPN #116 indicated that the specified device was incorrectly applied. RPN #116 was able to apply the specified device correctly. On an identified date in July 2018, the Administrator acknowledged that the specified device was not applied correctly for resident #008.

The licensee failed to ensure that the specified device was applied for resident #008 in accordance with manufacturer's instructions. [s. 110. (1) 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 and ensuring that when restraining a resident by a physical device, the physical device was applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #8: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

According to resident #020's clinical record dated July 2018, the resident was prescribed identified medication for the identified frequency and time. During a review of the home's identified report, it was initially identified that there was a missing dose on an identified date in July 2018. After an investigation into the incident, the home identified that agency RN #121 had administered identified medication during the identified medication pass on an identified date in July 2018 and did not sign that they had administered the medication.

According to the DOC, RN #127, working on the first floor that evening, had been called by the family of resident #020 as the resident had just called them indicating that they did not receive their medications yet. RN #127 then went up to the second floor unit shortly after receiving the call and administered the resident's identified medication; however, the medication had already been given by agency RN #121 but they did not sign that it had been given. The resident received two doses of the identified medication at identified time instead of one.

It was confirmed through review of the documentation and through discussions with the DOC that the licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (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 and ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of a CIS report #2890-000012-18, indicated that on an identified date in April 2018, resident #004 had an incident. A review of a progress note dated on an identified date in April 2018, indicated that the resident's family member had informed the long-term care facility that the resident had sustained an identified injury and was awaiting an identified intervention.

A review of the resident's assessments indicated that an identified assessment had not been conducted for this incident that resulted in an identified injury of the resident.

During an interview with the Administrator and DOC on an identified date in August 2018, the DOC indicated that it was the home's expectation that an identified assessment was conducted for resident #004, following this identified incident. The DOC and the Administrator confirmed that no identified assessment had been completed when resident #004 had an identified incident and sustained an identified injury.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #008925-18, conducted concurrently during the RQI. [s. 49. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once in every year, a survey was taken of the residents' families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

On an identified date in August 2018, during an interview with the Family Council representative, the LTC Homes Inspector was informed that they did not recall that satisfaction survey for the residents' families was conducted in 2017. Interview conducted on an identified date in August 2018, with the Social Worker and Admissions Co-ordinator indicted that the satisfaction survey was not conducted for the residents' families in 2017, which was acknowledged by the Administrator.

The licensee failed to ensure that in 2017 a survey was taken of the residents' families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. [s. 85. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition; and as indicated under r. 3.1: Where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine within one business day whether the injury had resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury had resulted in a significant change in the resident's health condition; and (b) where the licensee determined that the injury had resulted in a significant change in the resident's health condition or remained unsure whether the injury had resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A review of progress notes dated on an identified date in May 2018, at identified hours for resident #009, indicated that the resident was seen to be in identified position in the identified location in the home. The resident sustained identified injuries.

Review of a progress note dated on an identified date in May 2018, indicated that the resident was demonstrating identified signs of injury. The resident verbalized that they did have an identified incident on an identified date in May 2018. An identified intervention for the identified body sites of the resident was ordered. Review of the identified intervention results dated on an identified date in May 2018, indicated that the resident had an identified injury. The resident's physician was notified and referred the resident to an identified medical specialist. A progress note dated on an identified date in May 2018, indicated that the resident was transferred to the hospital for an identified medical procedure. A progress note dated on an identified date in June 2018, indicated that the resident returned back from the hospital to the LTC facility.

A review of the resident's clinical record indicated that MDS assessment had been conducted with an assessment reference on an identified date in June 2018.

During an interview with the RAI Co-ordinator on an identified date in July 2018, they confirmed that the resident did sustain an identified change in their status in some of the identified areas of Activities of Daily Living (ADL). A review of the identified change in status RAP, dated on an identified date in June 2018, indicated under ADL, that the resident identified mobility status was changed. The RAI Co-ordinator indicated that the resident's another identified status was also changed. The RAI Co-ordinator confirmed that an interdisciplinary review of the residents care plan had been completed.

A review of the resident's clinical records indicated that the resident had a diagnoses of identified health conditions. A review of the resident's clinical record for an identified period in May 2018, had not identified any documentation of any further incidents.

During an interview with the Administrator on an identified date in July 2018, they confirmed that the Director had not been informed of the resident's identified injury resulting in an identified change in condition. During an interview on an identified date in August 2018, with the DOC, they indicated that the home had not informed the Director as they had not felt that the incident involving the resident on an identified date in May 2018, had caused the identified injury. The DOC indicated that following the resident's incident, the resident had verbalized identified signs; however, verbalization of identified signs was not new and no symptoms had been present from the time of the resident's incident until an identified date in May 2018.

During an interview with the Administrator on an identified date in August 2018, they confirmed that the Director had not been notified following an incident that caused injury

to resident #009, for which the resident was taken to a hospital and that resulted in a identified change in their health condition. [s. 107. (3.1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member:

1. The staff member's qualifications, previous employment and other relevant experience.

Under the LTC Homes Act, 2007, "staff" was defined as:
"staff", in relation to a long-term care home, meant persons who worked at the home,

(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

A concern was brought forth related to agency staff that have been working in the home that were not qualified as PSWs.

The home had an agreement dated on an identified date in December 2016 with the identified agency, who supplied PSWs and registered staff to the home when the home could not fill shifts with employees of the home.

The agreement indicated the following:
An identified agency should maintain a worker file on each of its contractors containing the following:
an identified agency would provide copies of the following except a) to the facility.

a. Completed application, which includes education, training, skills, specialities and preferences
b. Skills inventory checklist
c. Tuberculosis (TB) test and evidence of satisfactory health status
d. Current Cardiopulmonary Resuscitation (CPR)
e. Performance evaluation
f. Copy of current license, registration or certification
g. Criminal background checks

During this inspection, on an identified date in August 2018, the LTC Homes Inspector requested personnel files of an identified agency's PSW staff, who worked regularly in the home to confirm their qualifications. The home did not have copies of these files.

During an interview with the DOC on an identified date in August 2018, the DOC indicated that the home had requested copies of the agency staff's records; however, the agency had not provided them to the home as indicated in their contract.

It was confirmed during interview with the DOC on an identified date in August 2018, that the home did not have records for each staff member of the home that included their qualifications, previous employment and other relevant experience.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection log #013325-18 conducted concurrently during the RQI. [s. 234. (1) 1.]

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

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Issued on this 18th day of October, 2018

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

Original report signed by the inspector.