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
Nov 28, 2017	2017_606563_0019	013235-17	Resident Quality Inspection

Licensee/Titulaire de permis

Blue Water Rest Home Inc.
37792 Zurich-Hensall Rd RR #3 ZURICH ON N0M 2T0

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

BLUE WATER REST HOME
LOT 21, HWY 84 R. R. #3 ZURICH ON N0M 2T0

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

MELANIE NORTHEY (563), MARIAN MACDONALD (137), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 26 and 27, 2017

The following intakes were completed within the RQI:
Log #033689-16 - Complaint # IL-48250-LO related to staffing in the home
Log #000185-17 - Critical Incident #C508-000013-16 related to falls
Log #018141-17 - Critical Incident #C508-000006-17 related to resident to resident suspected abuse
Log #020316-17 - Critical Incident #C508-000007-17 related to falls
Log #022194-17- Complaint # IL-52977-LO related to resident to resident suspected abuse

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of care, the Outreach & Program Manager, the Resident Assessment Instrument Coordinator, the Therapy Services Coordinator, the Registered Nurse Clinician, Registered Nurses, Registered Practical Nurses, Personal Support Workers, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place was complied with.

Ontario Regulation 79/10, s. 68(2)(e) related to the organized program of nutrition care and dietary services states, "Every licensee of a long-term care home shall ensure that the programs include, a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, and body mass index and height upon admission and annually thereafter."

Record review of the "Blue Water Rest Home Current Weights and Vitals" Report in Point Click Care (PCC) documented 13 residents with heights measured between 2012 and 2015. Nine residents were measured for height between January and March 2016; up to nine months overdue.

Record review of the "Height Assessment" policy #FSER_4_24 dated July 2015 stated height was an important measurement required to determine a resident's body mass index (BMI). The resident's height measurement would be taken upon admission and annually thereafter. The height was to be document in centimetres on the resident's record in PCC. Annually at the time of the annual care conference each resident’s height should be measured once again so an accurate BMI can be completed.

The Resident Assessment Instrument Coordinator (RAI-C) stated that residents were to be measured for height on admission and annually at the time of the annual care conference.

The licensee failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record height upon admission and annually thereafter. [s. 8. (1) (b)]

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was a pattern during the course of this inspection. There is a compliance history of this legislation being issued in the home on April 13, 2015 as a Voluntary Plan of Correction (VPC) during Resident Quality Inspection (RQI) #2015_217137_0017, on April 20, 2015 as a VPC during Complaint #2015_264609_0023 and on August 16, 2016 as a VPC during RQI #2016_206115_0027.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents and were locked when they were not being supervised by staff.

The Inspector observed that the servery area in both dining rooms had half wooden doors which were equipped with a push button mechanism on the inside. This mechanism did not restrict unsupervised resident access to these areas. By reaching over and pressing the release button, the servery areas were easily accessible to residents, staff and visitors. The steam tables in both servery areas could not be touched due to extreme heat, and toasters, microwaves and food items were accessible in the refrigerators and cupboards. Residents were observed seated in these areas with no staff present to provide supervision.

The Chief Executive Officer (CEO) observed the servery areas with the Inspectors and said that residents have had to be redirected from these areas and that family members used the serveries. The CEO said the servery doors were not equipped with locks to restrict unsupervised access and that it posed a potential risk to residents.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents and were locked when they were not being supervised by staff. [s. 9. (2)]

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years.

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 doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and are locked when they were not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living was included in a resident's plan of care only if the PASD had been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations; and the use of the PASD had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

During the course of the inspection a resident was observed on multiple occasions with a PASD in use.

Review of the current care plan in Point Click Care (PCC) documented that the resident used the PASD.

Review of the "Restraints" progress note in PCC stated the resident used a PASD and was unable to release the PASD without physical assistance.

Review of the resident's hard paper chart noted there was no consent for the use of the PASD. There was no physician's order or registered staff approval for the use of the PASD.

The Registered Practical Nurse (RPN) shared that the resident used a PASD for support and safety measures. The RPN verified that the resident also used a PASD for comfort and positioning.

The resident stated that they could not undo the PASD. Resident was capable of communicating their needs to the staff.

The Personal Support Worker (PSW) shared that the resident would not be able to undo the PASD without staff assistance.

The Director of Care (DOC) acknowledged that there was no consent for the PASDs in use.

The licensee failed to ensure that the PASD was approved for use by the appropriate persons set out in the legislation and the use of the PASD had been consented to by the resident or substitute decision-maker of the resident. [s. 33. (4)]

2. During the course of the inspection a resident was observed on multiple occasions with a PASD in place.

Review of the current care plan in Point Click Care (PCC) documented that the resident used a PASD for positioning.

Record review of the most recent completed MDS Assessment stated the resident used

a safety device.

Review of the "Occupational Therapy" (OT) progress note in PCC stated the PASD put in place before the OT approved it's use.

The RPN shared that the resident used a PASD for comfort and positioning.

The Personal Support Worker (PSW) shared that the resident had a PASD was in place as a safety measure.

The DOC #101 acknowledged that there was no order or consent for the use of the PASD when the device was initially used by the resident.

The licensee failed to ensure that the PASD was approved for use by the appropriate persons set out in the legislation and the use of the PASD had been consented to by the resident or substitute decision-maker of the resident. [s. 33. (4)]

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years.

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 use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in a resident's plan of care only if the PASD had been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations; and the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the most recent completed Minimum Data Set (MDS) Assessment documented that three residents were incontinent. The Resident Assessment Protocol (RAP) documented that residents had incontinence and wore an incontinence product.

Review of the "Screening Continence Assessment" completed in Point Click Care (PCC) documented that residents wore an incontinence product. The assessment identified the onset, duration and symptoms of incontinence, but did not identify the causal factors, patterns, type of incontinence or the potential to restore function.

The Chief Executive Officer (CEO), DOC and Registered Nurse Clinician shared that the Screening Continence Assessment in PCC was completed on admission and quarterly; and the Comprehensive Continence Assessment was completed if there was a significant change or if the resident’s current incontinence product proved ineffective. The CEO acknowledged that the Screening Continence Assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread for three of three residents during the course of this inspection. There is a compliance history of this legislation being issued in the home on April 13, 2015 as a Voluntary Plan of Correction (VPC) during Resident Quality Inspection (RQI) #2015_217137_0017 and on August 16, 2016 as a VPC during RQI #2016_206115_0027.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: 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, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The RPN shared that resident had altered skin integrity and required a specific intervention and a weekly assessment was completed in Point Click Care (PCC).

The Registered Nurse Clinician (RNC) verified that the resident had altered skin integrity. The Inspector and the RNC reviewed the most recent weekly assessments completed in PCC. The resident’s altered skin integrity was not assessed weekly.

The RNC acknowledged that there were multiple missing weekly assessments related to the resident’s altered skin integrity. The RNC shared that the resident’s altered skin integrity had healed multiple times and verified that the registered staff were to identify in the weekly assessment whether it was an initial, weekly or healed assessment. The RNC acknowledged that from the documentation in the weekly assessments for the resident, there was no evidence of when the resident's skin healed on multiple occasions over several months.

The licensee failed to ensure that the resident’s altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy under section 29 of the Act deals with the duties and responsibilities of staff, including who has the authority to apply a physical device to restrain a resident or release a resident from a physical device; types of physical devices permitted to be used; how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act was to be obtained and documented; alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an interdisciplinary approach; how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

The "Use of Restraints" policy #NRSG_10_2 last revised March 2016 did not document the duties and responsibilities of the staff. The policy outlined that a restraint required consent, care planning, and monitoring; but lacked the required information related to staff responsibilities. The policy also lacked the information related to who was responsible for obtaining and documenting consent and the authority related to the application and removal of a restraint. The policy documented those devices that were not permitted for use at Blue Water Rest Home; but not the devices that were permitted for use. The policy stated, "Try alternative methods prior to giving the medication" under the chemical restraint section of the policy. Alternatives to the use of physical devices was absent in the policy, including how those alternatives were planned, developed and implemented using an interdisciplinary approach. The policy documented an ongoing review of the resident's ongoing needs through the quarterly Resident Assessment Instrument (RAI), but did not document how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

The Director of Care acknowledged that the "Use of Restraints" policy #NRSG_10_2 was not in accordance with the Act and this Regulation. [s. 109.]

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the medication incidents for July to September 2017 showed there were thirteen medication omission incidents. The pharmacy was notified of all incidents, the attending physician was notified for eleven of the thirteen (84.6 per cent) incidents and family/Power of Attorney (POA) were only notified for one of thirteen incidents (7.7 percent) of incidents.

The Director of Care said not all family members/POAs had been notified of the medication incidents where an omission of a medication had occurred.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1) (b)]

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years.

Issued on this 29th day of November, 2017

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

Original report signed by the inspector.