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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2016_393606_0016	030263-16	Resident Quality Inspection

Licensee/Titulaire de permis

COLLINGWOOD NURSING HOME LIMITED
250 CAMPBELL STREET COLLINGWOOD ON L9Y 4J9

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

COLLINGWOOD NURSING HOME
250 CAMPBELL STREET COLLINGWOOD ON L9Y 4J9

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

JANET GROUX (606), DIANE BROWN (110), SIMAR KAUR (654)

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): October 25, 26, 28, 31, November 1, 2, 3, 4, 7, 8, 9, 10, and 14, 2016.

The following intakes were inspected concurrently with the Resident Quality Inspection (RQI):
Two Critical Incidents regarding resident falls resulting in a medical condition
A Complaints (CO) related to resident safety and resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Services (DRS), Assistant Director of Care (ADOC), Director of Operations, Maintenance Manager (MM), Physiotherapist (PT), Dietitian, Dietary Manager (DM), Dietary Aide (DA), Cook, Convalescant Care Manager (CCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Service Contractor, Substitute Decision Makers (SDM), and Residents.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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.

Resident #005 triggered during stage one of the Resident Quality Inspection (RQI) related to signs of dehydration.

Record review of resident #005's plan of care identified the following intervention under the focus of dehydration related to low fluid intake.

-Refer to the RD for evaluation/recommendations as clinically indicated in the Policy and Procedure (P&P).

Interviews with the RD and RPN #134 confirmed the intervention did not provide clear direction to staff and both staff were unable to explain the requirements of the intervention.

Interview with the ADOC stated the intervention did not provide clear directions on how to increase fluid intake for resident #005 [s. 6. (1) (c)]

2. Resident #001 triggered during stage one of the RQI related to signs of dehydration.

Record review of resident #001's plan of care identified the following interventions under the focus of inadeqate fluid intake.

-Refer to the RD for evaluation/recommendations as clinically indicated in P&P.

Interviews with the RD and RPN #134 confirmed the intervention did not provide clear direction to staff and both staff were unable to explain the requirements of the intervention.

Interview with the ADOC stated the intervention did not provide clear directions on how to increase fluid intake for resident #001. [s. 6. (1) (c)]

3. Resident #003 triggered during stage one of the RQI related to signs of dehydration.

Record review of resident #003's plan of care identified the following interventions under the focus of dehydration related to not consuming all liquids.

-Refer to the RD for evaluation/recommendations as clinically indicated in P&P.

Interviews with the RD and RPN #134 confirmed the intervention did not provide clear direction to staff and both staff were unable to explain the requirements of the intervention.

Interview with the ADOC stated the interventions did not provide clear directions on how to increase resident #003's fluid intake. [s. 6. (1) (c)]

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

During stage one of the RQI, resident #008 triggered for a potential restraint from an observation.

Record review of resident #008's Minimum Data Set (MDS) assessment on an identified date indicated he/she uses an identified restraint to an identified area of his/her body. Further review of the resident's Restraint /Personal Assistive Service Device (PASD) assessment on an identified date revealed the identified restraint application was in place

as a request from the family, to prevent injury to him/herself and others, and from transferring him/herself out of the mobility aide without assistance.

Review of resident #008’s plan of care indicated the following:
-Apply the identified device while sitting in the mobility aide.
-Monitor hourly for safety, and every two hours (Q2hrs) remove the identified device, provide care as required, reposition and reapply the identified device and;
-RN/RPN to reassess the ongoing need for the identified device every eight hrs (Q8hrs).
The Falls Prevention Team will assess and review the ongoing need for the identified device or a least restrictive device on a monthly basis.

Record review of resident #008’s assessments indicated there was no Restraint/PASD assessment completed after an identified date.

Interview with PSW #102 indicated an identified device is used for resident #008 when he/she was in his/her mobility aide on a daily basis.

Interview with RN #122 indicated it is the home's practice for the registered staff to assess all residents using the Restraint/PASD assessment to review and evaluate the resident's need for a restraint and/or PASD. He/she confirmed resident #008 was assessed on an identified date for an identified restraint, but has not been reassessed in the last seven months.

Interview with the ADOC confirmed resident #008 should have been assessed for his/her identified restraint on monthly basis according to his/her plan of care but had not been since the above mentioned identified date. [s. 6. (7)]

5. Review of an identified CI and date reported resident #004 fell sustaining a medical condition to two identified areas of his/her body.

Record review of resident #004’s progress notes indicated the resident had physical and cognitive impairments and was at high risk of falls. Further review of the resident’s fall history indicated the resident fell on three identified dates in 2015, and on the identified date in 2016, sustained an identified medical condition to two identified areas of his/her body. Further review of the resident's plan of care revealed resident #004 was on the home's "Falling Leaf Program" and was identified by an identified logo attached to his/her wheelchair to alert staff that he/she was at high risk of falling.

During multiple observations on November 8 and 9, 2016, the inspector observed resident #004 sitting in his/her wheelchair and noted the identified logo was not attached to the wheelchair to identify that the resident was on the "Falling Leaf Program".

Interviews with PSW #100 and RN #110 indicated the resident was high risk of falls, and he/she was on the Falling Leaf Program. They confirmed resident #004's wheelchair should have had an identified logo to alert staff that the resident was at high risk for falls.

Interview with the ADOC confirmed the home has a "Falling Leaf Program", and residents who are at risk for falls are required to have an identified logo that is visible for everyone to see on their mobility aides. [s. 6. (7)]

6. On October 28, 2016, inspectors #110 and #606, and the home's ADOC observed resident #021 sitting in a wheelchair that was in an identified position with his/her legs and feet dangling, off the floor, without footrests in place for support.

Interview with PSW #125 confirmed the resident normally had footrests in place when he/she is sitting in the wheelchair.

Record review of resident #021's plan of care identified him/her on a turning and positioning program and for staff to ensure the resident's legs/feet are well supported and not dangling.

Interview with the ADOC confirmed the resident should have had a foot rest in place and that the plan of care was not followed. [s. 6. (7)]

7. Resident #005 triggered during stage one of the RQI related to signs of dehydration.

Record review of residents #005's plan of care identified the following intervention under the focus of dehydration related to low fluid intake and an identified medical condition.

-Monitor and record fluid intake, analyze intake every 24 hours (q24 hrs) and notify the RD if actual intake below recommended intake for three days in a row.

Record review of the 'Charge Nurse Report Sheet Low fluid Intake Report between two identified months in 2016 identified the nursing staff had monitored resident #005's fluid intake and that his/her fluid intake fell below his/her recommended intake for three days in a row on five occasions during this period. The third day below the recommended

intake was triggered on five identified dates in 2016.

Interview with the FSM confirmed the resident’s fluid intake was below the resident's estimated needs for three consecutive days as noted above.

Interview with RPN # 134 revealed the night RN reviews the fluid list and writes on a note identifying residents on the dehydration list. He/she confirmed the day shift RPN would assess the resident for sign and symptoms of dehydration and if concerned will notify the RN, try and push fluids, monitor the resident closely and contact the MD. The RPN stated he/she has never notified the RD.

Record review revealed there were no referrals initiated for the RD on the five identified occasions noted above.

Interview with the newly hired RD, confirmed there was no evidence of referrals sent to the RD for these times of low fluid intake.

Interview with the ADOC stated that if a resident’s fluid intake falls below his/her recommended intake for three days in a row, a referral note is entered by the nursing staff into the point of care (POC) and a referral is sent to the RD for new interventions. The ADOC confirmed that referral notes were not entered and a referral to the RD was not sent on the above noted dates as required and that the care specified in the plan of care was not provided to resident #005. [s. 6. (7)]

8. Resident #001 triggered during stage one of the RQI related to signs of dehydration.

Record review of resident #001's written plan of care related to inadequate fluid intake identified an intervention for staff to offer an identified amount of millilitres (mls) of fluid per shift and encourage/assist resident to consume all fluids.

Interview with PSW #101 and #135 revealed an unawareness of the intervention for extra fluid.

Interview with RPN #134 confirmed the intervention was not monitored on the Medication Administration Record (MARs) and was unaware if staff were providing the identified fluid amount to the resident.

Interview with the ADOC revealed staff should be tracking the fluid intervention through

the MARs, by documenting in the progress notes or in the Point of Care's (POC) PRN (as needed) fluid intake task.

Review of the resident's POC tasks, progress notes and MARs failed to identify the provision of the extra fluid intervention.

The ADOC confirmed the care set out in the plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

9. Resident #001 triggered during stage one of the RQI related to signs of dehydration.

Record review of residents #001's written plan of care identified the following intervention under the focus of inadequate fluid intake.

-Monitor and record fluid intake, analyze intake every 24 hours and notify the RD if actual intake below recommended intake for three days in a row.

Record review of the POC look back report fluid intake between two identified months in 2016 identified 17 days when resident #001's fluid intake fell below his/her recommended intake three days in a row. The third consecutive day was identified on 17 identified dates in 2016 whereby resident fluid intake fell below his/her recommended intake.

Interviews with the FSM and RD indicated nursing staff provide the dietary department with a weekly Charge Nurse Report Sheet Low Fluid Intake Report that highlights residents when the fluid intake has fallen below his/her recommended intake for three consecutive days.

Record review of the available Charge Nurse Report Sheet Low Fluid Intake Report revealed incomplete weekly reports between two identified dates in 2016 with available records for only three identified weeks in 2016. Of the available records resident #001's name was highlighted on two of the identified weeks.

Record review of resident #001's progress notes between identified dates July to October 2016, failed to identify any referrals to dietary or the RD for a fluid assessment over this period of time.

Interview with the ADOC confirmed registered staff should be making a referral note to dietary on the third consecutive day resident's fluid intake fell below his/her

recommended intake and confirmed there were no referral notes identified.

The ADOC further confirmed that the care set out in the plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

10. Record review of resident #003's written plan of care identified the resident at high nutrition risk with an intervention to provide double portions for weight gain. The intervention was initiated on an identified date.

Record review of the resident's weight history report in POC identified resident #003's weights on two identified dates representing a weight loss.

On November 1, 2016, a meal service was observed. Resident #003 was served a regular portion size for turkey and cranberry sandwich with cucumber salad. Resident began eating his/her meal without prompting and 100 per cent of his/her meal was taken.

Interview with Cook #132 confirmed that a single portion was served.

A meal service was observed on November 4, 2016. Resident #003 was not provided double portions of food.

Interview with DA #133 confirmed the resident was served a single serving of toast, egg and banana as resident does not take cereal.

Interview with the RD confirmed staff are expected to serve double portions of the entrée at all meals and the care set out in the plan of care was not provided to resident #003 at the two meal services on the two identified dates. [s. 6. (7)]

11. Resident #003 triggered during stage one of the RQI related to signs of dehydration.

Record review of resident #003's MDS assessment on an identified date, identified the resident at risk for dehydration related to resident not always consuming all fluids offered to him/her.

The resident's written plan of care identified interventions that included staff to monitor and record fluid intake, analyze intake every 24 hours and to notify the RD if actual intake below recommended intake for three days in a row, and refer to the Dietitian for

evaluation/recommendations as clinically indicated in the Policy and Procedure.

Record review in POC assessments identified that resident #003 was assessed by nursing staff for signs and symptoms of dehydration on 13 occasions between two identified dates in April and July 2016. The POC assessments conducted on identified dates in April, May, and June, 2016, identified when resident #003's intake fell below his/her recommended fluid intake for three days in row.

Record review the POC look back report fluid intake confirmed resident #003's fluid intake had fallen below his/her recommended fluid intake for three days in a row, at least on 13 occasions between the identified dates in April and July 2016.

Interview with RPN #134 revealed the night RN reviews the fluid list and writes a note identifying residents on the dehydration list. He/she confirmed that the day RPN shift then would assess the resident for sign and symptoms of dehydration and if concerned notify the RN, try and push fluids, monitor closely and contact the MD. The RPN stated he/she has never notified the RD.

Record review revealed no referrals to the RD.

Interview with the newly hired RD, confirmed there was no evidence of referrals sent to the RD for these times of low fluid intake and resident #003 had not been assessed by the RD for hydration status between the identified dates in April and July 2016.

Interview with the ADOC stated if a resident's fluid intake falls below his/her recommended intake for three days in a row a referral note is entered by nursing into the POC and a referral is sent to the RD for new interventions.

The ADOC confirmed referral notes were not entered and a referral to the RD was not sent on the above noted dates as required and that the care specified in the plan of care was not provided to resident #003. [s. 6. (7)]

12. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During stage one of RQI, resident #008 was triggered for potential restraints from a resident observation.

Record review of resident #008's MDS assessment on an identified date indicated the use of an identified restraint device on the wheelchair. Further review of the clinical records indicated the resident has an identified restraint device application to prevent injury to self and others, and a request from the family.

Record review of resident #008's Quarterly Medication Review on an identified date by the physician indicated the following order:

Restraint -Three times a day (TID) every day, an identified restraint device to be in place. Further review of an identified Treatment Administration Record (TAR) of the resident revealed the restraint order were not signed for three identified dates in November of 2016, during an identified shift.

Interview with RPN #116 indicated resident #008 had an identified restraint device on his/her wheelchair, and is reassessed and documented on the TAR each shift to evaluate the effectiveness of the identified restraint. The RPN confirmed he/she had assessed the resident on the three identified dates and shift in November 2016 but did sign the TARs.

Interview with the ADOC confirmed registered staff are required to reassess the resident #008 each shift to evaluate the effectiveness of the restraint and sign the TARs. He/she further confirmed that staff did not document provision of care for the above mentioned dates. [s. 6. (9) 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 ensure that plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home assessed the resident's hydration status, and any risks related to hydration.

Resident #005 triggered during stage one of the RQI related to signs of a hydration status.

Record review of resident #005's MDS assessment on an identified date identified the resident at risk for dehydration.

Record review of the RD's assessment on an identified date in response to the resident's decreased nutritional status, included knowledge of resident #005's identified impaired skin integrity to an identified area of his/her body. The assessment did not address the risk of the identified nutritional status can be a sign and symptom of dehydration and impaired skin integrity can place a resident at risk of water deficit. A hydration assessment was not completed.

Record review of the RD's response to a referral for an identified skin integrity impairment assessment on an identified date identified resident #005's average fluid intake was an identified ml/day, meeting an identified per cent of an identified estimated fluid needs. This assessment also did not address the risk of impaired skin integrity place a resident at risk of water deficit and did not include a plan to address the fluid shortfall and further risk of dehydration.

Record review of the RD's response on an identified date, to resident #005's fluid intake further identified his/her fluid intake had fluctuated ranging from an identified ml/day and

did not always meet the resident's calculated fluid needs of an identified ml/day. The assessment did not include a plan to address fluid shortfall and risk of an identified medical condition.

Record review of the resident's MDS quarterly review assessment on an identified date, continued to identify resident #005 was at risk for dehydration related to insufficient fluid and the resident did not consume all or almost all liquids provided during the last three days.

On November 4, 2016, an identified meal service was observed and revealed resident #005 was not present. PSW #135 confirmed the resident does not attend the identified meal service based on the resident's preference.

On November 1, 2016, an identified meal service was observed and resident #005 was not offered milk, a standard fluid, part of the home's posted menu and hydration program according to policy #D009 titled "Hydration".

Record review of the resident's written plan of care including diet list did not identify the milk as a resident dislike.

Interview with DA #133 confirmed resident #005 does not have a known dislike for milk and that milk or a fluid equivalent was not offered as required.

Interview with PSW #136, identified resident #005 loves two identified fluids, and the resident will say no when you ask but he/she will drink it if you provide preferred fluids to him/her. The PSW identified this as a risk to the resident's hydration status.

An interview with PSW #135 revealed resident #005 does not attend an identified meal service due to the resident's preference and missing the identified meal would affect the residents overall fluid intake and was considered a risk to resident's hydration status.

Interview with PSW #101 revealed the resident's intake was poor because he/ she chooses not to drink and that the resident will indicate to the staff through an identified body language if you are forcing him/her to take a drink.

Record review of the home's policy entitled "#D009", dated "January 2014", titled "Hydration" directed the RD to review residents meal patterns/preference to determine if sufficient fluid was being served and to make adjustments as necessary.

Interview with the newly hired RD confirmed impaired skin integrity places a resident at risk of water deficit and reassessing fluid requirements was part of a nutritional assessment for impaired skin healing. That hydration status should be assessed when residents experience weight loss and that milk should have been served to resident #005 at an identified meal service as part of the home's hydration program and determining preferred fluids is part of a hydration assessment.

The RD failed to assess resident #005's hydration risks related to skin integrity impairment, access to all fluids from the planned menu and preferred fluids in addition to the impact of resident #005 weight loss and missing the identified meal service and the resident hydration status. [s. 26. (4) (a),s. 26. (4) (b)]

2. Resident #001 triggered during stage one of the RQI related to signs of dehydration.

Record review of resident #005's MDS assessment on an identified date, identified the resident at risk for dehydration related to resident does not consume all of his/her offered fluids and utilizes an identified medication daily, which puts him/her at risk for dehydration. The Resident Assessment Protocol (RAP) stated staff are to continue to offer/push fluids in order to address resident #001's risk for dehydration and a referral has been made to dietary regarding adequate hydration.

Record review of the RD assessment on an identified date identified the resident's fluid intake had fluctuated and ranged from an identified ml/day which did not meet his/her daily calculated fluid needs of an identified ml/day. The RD assessment further identified resident #001 had refused 18 meals within the past 14 days. The hydration plan identified was to monitor for signs and symptoms of dehydration.

Record review in POC identified the resident was assessed for signs and symptoms of dehydration on eight identified dates in 2016.

Interviews with DA #133 identified the resident was not a good drinker and often needed to be redirected back to the dining table to complete his/her meal.

Interview with PSW# 101 revealed resident #005 needed encouragement and exhibited an identified behaviour during meals that was identified as a risk to his/her intake.

Interview with RPN #134 identified resident #001's cognitive status and an identified

behaviours during meal times were risk factors to resident's poor fluid intake and hydration status.

Interview with the newly hired RD confirmed the use of an identified medication and the impact of an identified behaviour were two risk factors in assessing resident #001's hydration status.

The previous RD failed to assess resident #001’s hydration risks related to the use of an identified medication and the impact of the resident's identified behaviours during mealtimes were a risk to resident’s hydration status, when resident fluid intake was assessed as below his/her calculated fluid needs. [s. 26. (4) (a),s. 26. (4) (b)]

3. Resident #003 triggered during stage one of the RQI related to signs of dehydration.

Record review of #003's MDS assessment dated on an identified date identified the resident at risk for dehydration related to resident not always consuming all fluids offered to him/her.

Record review of the RD's assessment on an identified date revealed resident’s fluid intake fluctuated, ranging from an identified ml/day which usually met residents daily calculated fluid requirement. The assessment revealed knowledge of the resident's skin integrity impairment and that the resident was at high nutritional risk.

During the course of the inspection, for an identified time period, the inspector observed resident #003 in an identified position while in his/her wheelchair.

Interview with PSW#136 identified resident #003’s position of being in an identified position was normal and most definitely affected his/her fluid intake. PSW #136 stated at one point the resident went four days in the identified position when he/she would not sit up.

Interview with PSW #135 further identified the resident’s positioning in his/her chair impacts his/her fluid intake and that it was hard to get him/her sitting up.

Interview with the newly hired RD confirmed that the residents altered skin integrity and other identified predispositions risks to residents hydration status and that the hydration assessment on an identified date did not address the hydration risks to resident's hydration status when calculating resident estimated fluid needs. The RD confirmed that

resident's daily calculated fluid requirement would be greater than assessed.

The RD failed to assess resident #003's hydration risks impaired skin integrity, medical dispositions and positioning while in wheelchair.

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 the registered dietitian who is a member of the staff of the home assess the resident's hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #3: 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 the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of an identified CI on an identified date reported resident #004 fell sustaining an identified medical condition on two identified areas of his/her body.

Record review of the resident #004's progress notes indicated the resident had both physical and cognitive impairments and was at high risk of falls. Further review of the resident's fall history indicated resident #004 fell on three identified dates in 2015 before falling on an identified date in 2016.

The home's practice after a resident has fallen, directs registered staff to use the Morse Fall Risk Assessment on Point Click Care (PCC) to assess the resident. Review of the resident's assessment records did not indicate a post-fall assessment was completed for resident #004's fall on an identified date.

Interview with RN #122 indicated the resident fell on an identified date, from an identified mobility aide and hit an identified area of his/her body and confirmed a post fall assessment was not completed.

Interview with the ADOC confirmed the home uses Morse Fall Risk Assessment to assess a resident after a fall. He/she further confirmed a post fall assessment was not conducted on an identified date for resident #004. [s. 49. (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 to ensure that when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls if required, 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 has failed to ensure that a resident exhibiting altered skin integrity, such as a pressure ulcer or wounds, was assessed by a registered dietitian who is a member of the staff of the home.

Resident #002 triggered during stage one of the RQI related to an identified skin integrity impairment.

Record review of resident #002's progress notes on an identified date, indicated an identified a skin integrity impairment to an identified area of his/her body and verbalized that the identified area was sore the day before. Further review indicated a weekly skin assessment note indicated the identified area was at an identified level.

Record review of resident #002's progress notes and Point Click Care (PCC) assessments indicated his/her identified skin integrity impairment was not assessed by the RD when it was first observed on an identified date.

Record review of the home's policy entitled, "Wound and Skin Care Program", "section 4.16", last revised "November 15, 2015", and the home's skin care protocol entitled "Skin Dressing Protocol", directed the registered staff to refer the identified skin integrity concern to the RD.

Interview with RN #104 revealed residents with altered skin integrity are usually not referred to the RD unless the altered skin integrity is red and open and confirmed resident #002 was not referred to the RD.

Interview with RN # 110 revealed the home does not usually refer identified skin integrity concerns to the RD unless there are multiple areas.

Interview with the RD revealed the home's practice is any resident who exhibits any skin integrity impairment requires the registered staff to initiate and send a referral to the RD to assess the identified area and confirmed he/she did not receive one for resident #002. [s. 50. (2) (b) (iii)]

2. Resident #002 triggered during stage one of the RQI related to an identified skin integrity impairment.

Record review of resident #008's MDS assessment on an identified date, and skin assessment dated on an identified date indicated resident has an identified skin integrity impairment to an identified area of his/her body.

Record review of resident #008's progress notes and PCC assessments indicated that the resident's identified skin integrity impairment did not indicate any records that an RD assessment was completed.

Record review of the home's policy entitled, "Wound and Skin Care Program", "section 4.16", last revised "November 15, 2015", and the home's skin care protocol entitled "Skin Dressing Protocol" directed the registered staff to refer the identified area to the RD.

Interview with RPN #104 and RN #110 revealed resident #008's skin integrity impairment was not referred to the RD.

Interview with the RD revealed the home's practice is any resident who exhibits any skin integrity impairment requires the registered staff to initiate and send a referral to the RD to assess the identified area and confirmed he/she did not receive one for resident #008. [s. 50. (2) (b) (iii)]

3. Resident #002 triggered during stage one of the RQI related to an identified skin integrity impairment.

Record review of resident #009's MDS assessment on an identified date, and progress notes revealed he/she has an identified skin integrity impairment to three identified areas of his/her body.

Record review of resident #009's progress notes and PCC assessments indicated that the identified skin integrity impairment indicated no records that he/she was assessed by the RD.

Record review of the home's policy "Wound and Skin Care Program", "section 4.16", last revised "November 15, 2015", and the home's skin care protocol entitled "Skin Dressing Protocol" directed the registered staff to refer the identified area to the RD.

Interview with RN #104 revealed resident #009 has an identified skin integrity impairment to an identified area of his/her body and had identified treatment regimes.

Interview with RN # 110 revealed resident #009 has an identified skin integrity impairment to several identified areas of his/her body, and gets an occasional skin integrity impairment which was managed by an identified cream and weekly monitoring and therefore a referral to the RD was not initiated.

Interview with the RD revealed the home's practice is any resident who exhibits any skin integrity impairment requires the registered staff to initiate and send a referral to the RD to assess the identified area and confirmed he/she did not receive one for resident #009. [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, such as a pressure ulcer or wounds, is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items are offered at each meal and snack.

Resident #001 triggered during stage one of the RQI related to signs of dehydration.

On November 1, 2016, the inspector observed an identified meal service in the main dining room. Resident #001's water was pre-set at his/her designated dining table prior to resident arriving to the dining room. Within a few minutes resident was observed entering the dining room, sitting at his/her table and eating his/her meal. Resident was not offered milk after arriving to the dining room.

Interview with DA #133 confirmed that milk was not offered to the resident.

Record review of the dietary kardex did not identify milk as a dislike for resident #001.

Record review of the resident's written plan of care identified resident #001 with inadequate fluid intake.

An interview with PSW #136 revealed resident #001 needs a lot of encouragement to drink but will drink if you offer a drink to him/her. PSW #101 stated that resident needs encouragement to sit and drink but that there has not been an issue with his/her fluid intake.

Record review of the menu identified milk as part of the planned menu at the identified meal service on November 1, 2016.

Interview with the RD confirmed milk is part of the planned menu and that resident #001 should be offered milk at all meals. [s. 71. (4)]

2. Resident #003 triggered during stage one of the RQI related to signs of dehydration.

The inspector observed on November 1, during an identified meal service, and on November 4, 2016, during an identified meal service that resident #003 was not offered milk to drink.

Interview with DA #133 confirmed that milk was not offered to the resident.

Record review of the dietary kardex did not identify milk as a dislike for resident #003.

Record review of the resident's written plan of care identified resident #003 at high nutrition risk.

Review of the menu review identified milk as part of the planned menu at the identified meal service on November 1, and identified meal service on November 4, 2016.

Interview with the RD confirmed milk is part of the planned menu and that resident #003 should be offered milk at all meals. [s. 71. (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 planned menu items are offered at each meal and snack, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written record of annual evaluation of the falls prevention program that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During RQI inspection, a record review of the home's program evaluations did not indicate an annual evaluation of the falls prevention and management program for 2015.

Interview with the ADOC revealed he/she is a lead for the falls prevention program and indicated the 2015 Falls Program annual evaluation for was completed and the DRS would have the written records.

Interview with the DRS confirmed the annual evaluation of the falls prevention program was completed by the former DRS in 2015. He/she confirmed the home does not have the written record of the annual evaluation program for 2015 that includes the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented. [s. 30. (1) 4.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location.

During the initial home tour of the RQI inspection on October 25, 2016, two identified inspection reports were not posted.

The ADOC confirmed the identified reports were not posted as required. [s. 79. (3) (k)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead must have, (a) a post-secondary degree or diploma; (b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and (c) a minimum of two years experience in a managerial or supervisory capacity.

Review of an identified complaint received by the Ministry of Health and Long Term Care (MOHLTC) on an identified date indicated multiple concerns.

Record review of an identified home's file did not indicate the designated lead for the maintenance department met the requirements as outlined in the MOH regulation.

Interview with the Maintenance Manager indicated he/she does not have all the credentials required for the designated lead position as outlined in the MOH regulation.

Interview with the Administrator revealed he/she confirmed the designated lead did not have all the necessary credentials as indicated in the MOH regulation mentioned above but felt he/she was capable of managing his job responsibilities as the designate lead for the maintenance department for the home. [s. 92. (2)]

WN #9: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director an analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

Review of an identified CI and date reported resident #012 fell resulting in an identified medical condition.

Record review of resident #012's progress notes indicated resident fell four times during an identified dates in 2015 and was transferred to the hospital for further assessment after the resident verbalized pain to an identified area of his/her body. It was documented resident #012 returned from the hospital diagnosed with an identified medical condition.

Interview with the DRS revealed a CI was submitted on an identified date, and confirmed the CI was not amended to reflect the updated information as indicated in the legislation. [s. 107. (4) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept for annual evaluation of the restraint policy including the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented.

During RQI inspection, record review of the home's program evaluations did not indicate an annual evaluation of the restraints policy to determine the effectiveness of the licensee's policy.

Interview with the ADOC revealed that he/she is a lead for the Minimizing Restraint Program and indicated the 2015 Minimizing Restraint Program annual evaluation was completed and the DRS would have the written records.

Interview with the DRS confirmed the annual evaluation of the restraint policy was completed by the former DRS in 2015. He/she confirmed the home did not have the written record of the annual evaluation of the restraint policy including the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented. [s. 113. (e)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (3) The licensee shall keep a written record relating to each evaluation under subsection (2) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 216 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record relating to each evaluation under subsection (2) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The home's 2015 Staff Training and Evaluation records were not available for review.

Interview with the DRS confirmed the home had completed the required training and evaluations with all the staff in 2015 but was not able to locate the written records for them.

The home has failed to ensure that a written record relating to each evaluation under subsection (2) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the following requirements: A record must be maintained by the licensee setting out, i. the matters referred to in paragraph 3, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Record review of the home's 2015 annual evaluations of the abuse and neglect, falls prevention and management, skin and wound care program, were not available.

Interview with the DRS indicated the 2015 annual evaluations for the abuse and neglect, falls prevention and skin and wound program were completed but was not able to locate them.

The home has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the legislation.

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.