Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/GeNR/RCe d'inspection
April 26 to April 27, 2012 and April 30 to May 3, 2012 (onsite)	2012_2736_198_00004	Data Quality Inspection (Restorative Care and Therapies)

Licensee/Titulaire
Devonshire Erin Mills Inc.
195 Dufferin Ave., Suite 800
London, Ontario, N6A 1K7

Long-Term Care Home/Foyer de soins de longue durée
Erin Mills Lodge Nursing Home
2132 Dundas Street West,
Mississauga, Ontario, L5K 2K7
905 823-6700

Name of Inspector(s)/Nom de l'inspecteur(s)
Pat Ordowich (198) (Lead)
Nancy Rawlings (199)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Data Quality inspection related to restorative care and therapies.

During the course of the inspection, the inspectors spoke with: Administrator, Director of Nursing and Personal Care (DONPC), Assistant Directors of Resident Care (ADOCs), RAI Co-ordinator (RAI-C, who is also an ADOC), Restorative Care Coordinator (who is also an ADOC), and Physiotherapist (PT), Physiotherapy Assistant (PTA).

During the course of the inspection, the inspectors reviewed: resident health records for 10 residents in the home for the quarters from July 1, 2010 to March 31, 2011 and the most recent completed RAI-MDS 2.0 that was submitted to the Canadian Institute for Health Information (CIHI) for those residents who still lived in the home as well as the home policies and procedures for restorative care including therapies.

The following Inspection Protocol was used in part or in whole during this inspection: Restorative Care and Therapy.

☒ Findings of Non-Compliance were found during this inspection.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions that may have been used in this report.

VPC – Voluntary Plan of Correction/Plan de redressement volontaire
WN – Written Notifications/Avis écrit

ARD = assessment reference date
AROM = active range of motion
CIHI = Canadian Institute for Health Information
RAI-MDS 2.0 = Resident Assessment Instrument Minimum Data Set Version 2.0
NR/RC = Nursing Rehabilitation/Restorative Care
PROM = passive range of motion
PT = Physiotherapy
QHS = Every evening at bedtime
RAI-C = RAI Co-ordinator
RAPs = Resident Assessment Protocol

Q2 = July 1 to September 30, 2010
Q3 = October 1 to December 31, 2010
Q4 = January 1 to March 31, 2011
Most recent quarter inspected = October 1 to December 1 2011 or January 1 to March 31, 2012

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *Long Term Care Homes Act (LTCHA), 2007*, c. 8, s. 101.

(1) A licence is subject to the conditions, if any, that are provided for in the regulations. 2007, c. 8, s. 101.

(2) The Director may make a licence subject to conditions other than those provided for in the regulations,

(a) at the time a licence is issued, with or without the consent of the licensee; or

(b) at the time a licence is reissued under section 105, with or without the consent of the new licensee. 2007, c. 8, s. 101 (2).

(3) It is a condition of every licence that the licensee shall comply with this Act, the *Local Health System Integration Act, 2006*, the *Commitment to the Future of Medicare Act, 2004*, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

(4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101 (4);

Findings:

1. The Long-Term Care Homes Service Accountability Agreement (L-SAA) is an agreement entered into between the local health integration network and the Licensee, Devonshire Erin Mills Inc., under the *Local Health System Integration Act, 2006*. Compliance with the L-SAA is, therefore, a condition of the license issued to Devonshire Erin Mills Inc. for the Erin Mills Lodge Nursing Home.
2. The Licensee has failed to comply with the following provisions of the L-SAA:

Article 3.1

(a) The HSP will provide the Services in accordance with:
  (i) this Agreement;
  (ii) Applicable Law; and
  (iii) Applicable Policy.

Article 8.1

(a) The LHIN's ability to enable its local health system to provide appropriate, co-ordinated, effective and efficient health services as contemplated by LHSIA, is heavily dependent on the timely collection and analysis of accurate information. The Health Service Provider (HSP) acknowledges that the timely provision of accurate information related to the HSP is under the HSP's control;

Article 8.1(b): The HSP [Health Service Provider]

(iv) will ensure that all information is complete, accurate, provided in a timely manner and in a form satisfactory to the LHIN [Local Health Integration Network];

Article 8.1 (c): The HSP will:

(i) conduct quarterly assessments of Residents, and all other assessments of Residents required under the Act, using a standardized Resident Assessment Instrument - Minimum Data Set (RAI-MDS 2.0) 2.0 tool in accordance with the RAI-MDS 2.0 Practice Requirements included in Schedule F and will submit RAI-MDS 2.0 assessment data to the Canadian Institute for Health Information (CIHI) in an electronic format at least quarterly in accordance with the submission guidelines set out by CIHI; and

(ii) have systems in place to regularly monitor and evaluate the RAI-MDS 2.0 data quality and accuracy;

3. The RAI-MDS 2.0 LTC Homes – Practice Requirements are included in Schedule F of the L-SAA and fall within the definition of "Applicable Policy" under the L-SAA.
4. The RAI-MDS 2.0 Agreement between the Minister of Health and Long-Term Care and the Licensee, Devonshire Erin Mills Inc. is an agreement under the *Long-Term Care Homes Act, 2007* for the provision of funding related to the implementation of RAI-MDS 2.0 assessment tool in long-term care homes. Compliance with the RAI-MDS 2.0 Agreement is, therefore, a condition of the license issued to Devonshire Erin Mills Inc. for the Erin Mills Lodge Nursing Home.
5. The documents listed in Schedules A to E of the RAI-MDS 2.0 Agreement between the Licensee, Devonshire Erin Mills Inc. and the Ministry of Health and Long-Term Care fall within the definition of "Applicable Policy" in the L-SAA. These documents include, but are not limited to, the Sustainability Project Description, the Implementation Information Package together with the Training Module Overview, and the RAI Coordinator Role Description.
6. The level-of-care per diem funding in the Nursing and Personal Care (NPC) envelope paid by the local health integration network to the Licensee pursuant to the L-SAA is adjusted based on resident acuity. The higher the acuity, the greater the funding. The amount of funding in the NPC envelope is calculated using a formula set out in the LTCH Level-Of-Care Per Diem Funding Policy (a policy listed in Schedule F of the L-SAA) and resident acuity is determined using the RAI-MDS 2.0 information submitted by the Licensee to CIHI.
7. The incompleteness and inaccuracy of the RAI-MDS 2.0 data is evidenced by the following:
   (a) The RAI-MDS 2.0 coding was not supported by the home's documentation, including the residents' plans of care and the RAPs documentation. There were multiple inconsistencies between what was coded on the RAI-MDS 2.0 and the progress notes found in the residents' plans of care.
8. The following are specific examples of incomplete and/or inaccurate RAI-MDS 2.0 coding and non-compliance with the L-SAA and/or the RAI-MDS 2.0 LTC Homes – Practice Requirements and/or the Implementation Information Package and/or the RAI Coordinator Role Description and/or the RAI-MDS 2.0 Agreement. The RAI-MDS 2.0 Practice Requirements mandates the use of the RAI-MDS 2.0 Manual, which states that a rehabilitation or restorative practice must meet specific criteria including that measureable objectives and interventions must be documented in the care plan and in the clinical record.

   a. Resident 001

- There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received 7 days of NR/RC walking activity. However, the plan of care indicated that the resident was fully independent in walking using a cane. Therefore this did not meet the RAI-MDS 2.0 definition for the walking NR/RC activity as it must improve or maintain the resident's self-performance in walking, with or without assistive devices and the resident was already ambulatory.
- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 45 minutes during the 7-day observation period, however the PT activity log indicated that the resident received 2 days of PT for a total of 30 minutes.

b. Resident 002

- The RAI-MDS 2.0 was coded that the resident was on a NR/RC scheduled toileting plan however the NR/RC progress note indicated that the resident did not wish to continue with the voiding program. In the next quarter of the RAI-MDS 2.0, the resident was still coded as being on a scheduled toileting plan. The plan of care did not meet the wishes of the resident.
- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 50 minutes during the 7-day observation period, however the PT activity log indicated that the resident received 3 days of PT for a total of 45 minutes. The PT plan of care said in one area that the resident was to receive PT for 2 to 3 times per week and in another area said 50 minutes in total over 3 days per week. It was unclear how often the resident was to participate in PT activities.

c. Resident 003

- There were discrepancies between the coding of the RAI-MDS 2.0, documentation and the plan of care. The RAI-MDS 2.0 was coded that the resident was on a NR/RC transfer activity. However, the plan of care indicated that the resident was a one person physical assist, to encourage resident to request assistance of staff for transfers and to report any change in ability to transfer safely. This would not give clear direction to staff and others who provided direct care to the resident on NR/RC activities used to improve or maintain the resident's self-performance in moving between surfaces or planes with or without assistive devices as per RAI-MDS 2.0 definition.

d. Resident 004

- There were discrepancies within the coding of the RAI-MDS 2.0. The RAI-MDS 2.0 was coded that the resident was on a NR/RC activity of a scheduled toileting plan. The RAI-MDS 2.0 was also coded that the resident was totally incontinent of bowel and bladder. For the purposes of RAI-MDS coding, a toileting plan is used for continent residents. If the resident is routinely taken to the toilet at scheduled times (and not by request) but the resident does not eliminate in the toilet and the resident is still incontinent, this is not a toileting plan.
- There were discrepancies within the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident was on a bed mobility NR/RC activity however the RAI-MDS 2.0 was coded that the resident was totally dependent on 2 staff for bed mobility and the plan of care also said that the resident was totally dependent on staff. This did not meet the RAI-MDS 2.0 definition for bed mobility which are activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning self in bed.
- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 45 minutes during the 7-day observation period, however the PT activity log indicated that the resident received 2 days of PT for a total of 30 minutes.

e. Resident 005

- The RAI-MDS 2.0 was coded that the resident received PT for 3 days for a total of 48 minutes during the 7-day observation period however there was no PT plan of care provided. When questioned, the PT said on April 27, 2012 that it probably was not transferred over from the previous quarter.

f. Resident 006

- There were discrepancies within the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident was on a NR/RC eating or swallowing activity and the RAI-MDS 2.0 was also coded that the resident was totally dependent on staff for feeding. The plan of care indicated that the resident was totally dependent on staff for feeding and the RAP said that the resident was totally dependent on staff for feeding and that no choking episodes had been documented.

- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 45 minutes during the 7-day observation period, however the PT activity log indicated that the resident received 2 days of PT for a total of 30 minutes.

g. Resident 007

- There were discrepancies within the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident was on a NR/RC dressing or grooming activity for the 7 days of the observation period. However, the plan of care for dressing said that the resident required limited assistance, to praise accomplishments, the resident would choose outfit and staff to lay on bed and that staff assist with underwear, stocking and shoes. The plan of care for grooming said that the resident required limited assistance, and that staff apply skin lotion, perfume and make-up and that the resident tends to be independent and hesitant to ask for help. The RAPs documented that the resident was able to dress self. There is nothing in the plan of care that discusses activities uses to improve or maintain the resident's self performance in dressing and undressing, bathing and washing and performing other personal hygiene tasks.

h. Resident 008

- There were discrepancies within the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received 7 days of NR/RC walking activity and the RAI-MDS 2.0 was also coded that the resident was independent in walking in room and corridor. However, the plan of care indicated that the resident was fully independent with no help or oversight of staff. Therefore this did not meet the RAI-MDS 2.0 definition for the walking NR/RC activity as it must improve or maintain the resident's self-performance in walking, with or without assistive devices and the resident was already ambulatory.

- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 45 minutes during the 7-day observation period, however the PT activity log indicated that the resident received 2 days of PT for a total of 30 minutes.

i. Resident 009

- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident was on a NR/RC walking activity for 7-days of the observation period. However, the RAPs documented that the resident walks with PT with a walker and did not mention the NR/RC walking activity.

- The RAI-MDS 2.0 was coded that the resident received PT for 3 days for a total of 48 minutes during the 7-day observation period however there was no PT plan of care provided. When questioned, the PT said on April 27, 2012 that it probably was not transferred over from the

previous quarter.

j. Resident 010

- There were discrepancies within the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received 7 days of NR/RC walking activity and the RAI-MDS 2.0 was also coded that the resident was independent in walking in room and corridor. However, the plan of care indicated that the resident was fully independent in walking. Therefore this did not meet the RAI-MDS 2.0 definition for the walking NR/RC activity as it must improve or maintain the resident's self-performance in walking, with or without assistive devices and the resident was already ambulatory.

- There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident had no limitation in functional range of motion for all limbs and was also coded that the resident received 3 days of PT for a total of 45 minutes during the observation period. However, the PT plan of care indicated that functional range of motion of limbs was within normal range but that the resident was to receive AROM strengthening exercises of the all quads and hips 3 times a week. There was no supporting documentation for the reason or evaluation of AROM exercises given that the resident had no limitation in functional range or motion for all limbs.

Inspector ID #:	198, 199

Additional Required Actions:

Voluntary Plan of Correction (VPC) - Pursuant to the Long Term Care Homes Act (LTCHA), 2007, c.8, s.101, the licensee is hereby requested to prepare a written plan of corrective action to ensure compliance with the RAI-MDS 2.0 Long Term Care Homes Practice Requirements, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Pat Ordenick
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). August 9, 2012