Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 28, 2014	2013_266527_0004	H-000929-13	Complaint

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7

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

KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 27, 2013 and January 3, 2014.

The Inspector conducted an inspection related to Complaint H-000929-13.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Nursing staff, the Assistant Directors of Care (ADOC) and Leads for the Falls Program and Bladder Management Program, and the Director of Care (DOC).

During the course of the inspection, the inspector(s) reviewed the resident's clinical records, policies and procedures, the Falls Management Program, the Bladder Management Program, the critical incident investigative notes, the clinical record from the hospital and conducted observations in common areas of the home and residents rooms.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with 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 did not ensure the plan, policy, protocol, procedures, strategy or system is complied with.

1) The Falls Prevention Assessment and Management policy, document number RCM04-04-01 dated August 2011 states that registered staff will complete a referral for residents identified as being at risk for falls, along with those that have fallen. Physiotherapy do complete gait and balance assessment on admission and post fall. There is no clinical documentation provided by the home that reflects a referral for Resident #001 post fall assessment by physiotherapy in July or August 2013. There has been no referral for physiotherapy since the resident has returned from the hospital post fall in December 2013. Registered staff said they will sometimes refer to physiotherapy when residents fall, but could be waiting a week for them to assess as they are only in the home one day per week providing services, therefore referrals don't occur routinely to physiotherapy for post-falls assessments.

2) The Bladder Management Program policy, document number RCM04-03-03 dated August 2011 identifies that on completion of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0 on admission, quarterly and with a significant change in status the level of the resident's bladder continence/incontinence will be identified. Also, documented in the home's 2013 Goals for the Continence Team, they identified that all residents coded as frequently incontinent of urine will be assessed for a toileting trial from October 1 - December 31, 2013. Resident #001 had a significant change in the quarterly assessment November 2013 from occasionally to frequently incontinent. The Continence Program Lead/Assistant Director of Care confirmed the resident was not on a continence program and there was no toileting trial conducted as per their policy. In addition, the ADOC confirmed they don't have an assessment tool. The direct care providers confirmed that no toileting trial was conducted for Resident #001. [s. 8. (1) (b)]

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 plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: 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. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee did not ensure the Falls Prevention and Management Program has equipment in good working order, and monitoring protocols to reduce or mitigate falls.

The Director of Care informed that the home does not conduct routine audits on bed and chair alarms to ensure they are in working order. The Falls Lead/ADOC informed there is a verbal expectation that staff check the alarms each shift, but there is no written protocol or documentation of alarm checks. The staff said they only know the alarm is not working, when the resident gets up from the bed or chair and the alarm doesn't sound. The DOC's critical incident investigation notes identifies that staff who worked the shift in December 2013 when resident #001 had an unwitnessed fall, were unsure as to whether the bed alarm was working and there is no documentation of alarm checks being conducted. Staff confirmed there have been other incidents when bed and chair alarms did not sound and were not working when residents have had a fall. [s. 49. (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 to ensure the falls prevention and management program, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure the written plan of care for resident #001 sets out the planned care, the goals the care is intended to achieve, and clear directions to staff and others who provide direct care.

The November 2013 plan of care identifies resident #001 as a one person physical assist, toilet routinely to prevent falling, as the resident does know the need to toilet, and identifies the resident as an extensive assist with toileting. The plan of care also directs staff to toilet before and after breakfast, lunch and supper, however there is no documentation as to the toileting routine and expectations between 2100 to 0600 hours. The Charge Nurse did not know what they do for the resident's toileting needs at night. The interventions on the written plan of care do not meet the individualized needs of resident #001. [s. 6. (1) (c)]

2. The November 2013 written plan of cares states staff to check resident hourly for safety and help for toileting and transfers. The interventions and staff assistance identified on the plan of care for resident #001 was inconsistently documented on the

November 2013 Observation / Flow Sheet, and did not reflect the frequency of hourly checks for safety, and assistance provided to the resident for toileting and transfers. [s. 6. (7)]

3. The written plan of care identified resident #001 required one bed rail. Resident #001 was observed with both quarter bed rails up. [s. 6. (7)]

4. The Quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and Resident Assessment Protocols(RAP) 2013 assessments identified status changes in November 2013 for resident #001 related to toileting/urinary, falls and the use of bed rails, however no revisions were noted in the November written plan of care. The written plan of care for December 2013 identifies resident #001 as occasionally incontinent, two plus times a week but not daily. The November 2013 quarterly re-assessment coded resident as frequently incontinent. This change was not updated on the written plan of care.

Resident #001 returned from Hospital December 2013 and status and care needs had changed. The written plan of care for December 2013 states that resident #001 is occasionally incontinent, wears mesh pants with a day plus liner, and is to be toileted routinely. Staff stated that resident is incontinent at all times and wears a brief since returning from the hospital. This was also confirmed in the documentation on the resident's clinical record. The written plan of care also identifies resident #001 as a one person assist for transferring and for walking in room. Staff confirmed resident is too weak to transfer with one person and is unable to walk in the room. The documentation of care provided to the resident was noted as extensive assist, but mostly total dependence for transferring, and that activities related to walking did not occur. The written plan of care was not updated to reflect the change in the resident's care needs. [s. 6. (10) (b)]

WN #4: 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).

s. 33. (5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations. 2007, c. 8, s. 33. (5).

Findings/Faits saillants :

1. The Licensee did not ensure the use of a Personal Assistance Services Device (PASD) for resident #001 was included in the plan of care, that alternatives have been considered, the use of a PASD is reasonable for this resident, and the PASD has been approved by a member of a regulated profession, and a consent obtained from the resident or substitute decision maker.

Resident #001 written plan of care identifies quarter rails to assist with routine activities of daily living. There is no documentation in the clinical record of the PASD being approved by a physician, registered staff or any other person provided for in the regulations. This was confirmed by registered staff. Staff confirmed there was no physician or Nurse Practitioner order on the resident's chart, and they were not aware the quarter rails used by the resident was a PASD. [s. 33. (4) 3.]

2. Resident #001 uses quarter rails to assist with routine activities of daily living. There is no documentation on the clinical record of a consent from the substitute decision-maker for the use of PASD. This was confirmed by the registered staff and the Falls Lead/Assistant Director of Care. [s. 33. (4) 4.]

3. Resident #001 was observed in December 2013 in bed with both quarter rails up, plan of care for December 2013 identified "one bed rail for bed mobility", and in the transferring section of the written plan of care it states "Bed rails used for bed mobility or transfers. Uses 1/4 length rails". Staff interviews confirmed resident uses bed rails to assist with activities of daily living, but didn't identify the bed rails as a Personal Assistance Device (PASD).

No consent on clinical record for the Personal Assistance Services Device. [s. 33. (5)]

Issued on this 6th day of February, 2014

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

Kathleen Millar