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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2017	2017_674610_0011	021953-17	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

EXETER VILLA
155 JOHN STREET EAST EXETER ON N0M 1S1

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

NATALIE MORONEY (610), ADAM CANN (634), CAROLEE MILLINER (144), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 18, 19, 20, 21, 22, 26, 27, and 28, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Administrator Assistant, Director of Support Services, Registered Nurses, Registered Practical Nurses, Director of Activities and Volunteer Services, Personal Support Workers, Staff Educator, Director of Restorative Care, Pharmacy Consultant, the Cook, Dietary Aides, Housekeeping Staff, family, Residents' Council Representatives and over forty residents.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interactions, dining services, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident 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. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident may be restrained by a physical device if the restraining of the resident was included in the resident's plan of care.

Observations were completed on three days, that showed the resident was using a restraint device.

A review of the resident's plan of care showed that there was no current restraint assessment completed, no current physician order for the use of the restraint, or consent from the Substitute Decision Maker for the use of the restraint and the restraint was not part of the plan of care.

Further review of the resident's health care record (HCR) in the paper chart kept at the nurse's station showed an incomplete interdisciplinary restraint assessment. There was no current physician orders for the use of the restraint that consent for the restraint from the SDM had been obtained.

The Physical Restraint Policy Revised March 5, 2015, stated in part that the restraint alternative assessment form would be completed, all alternatives would be tried, the resident or the Substitute Decision Maker would sign the consent, a physician order would be obtained and documented, and the registered nurse would update the care plan to indicate the use of the restraint.

The Director of Care (DOC) said that the resident's was using a restraint. The Director of Care further said that they had not completed a restraint assessment and the restraint was not part of the plan of care.

The licensee has failed to ensure that the resident had a plan of care for the use of the restraint that had restraining qualities. [s. 31. (1)]

2. The licensee has failed to ensure that restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk. 5. The restraining of the resident 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. 6. The plan of care did not provide for everything required under subsection 3 for the use of restraints.

Long-Term Care Homes Act, 2007, c. 8, s. 31. (3) (d) states, If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided. for in the regulations.

Observation of a resident was completed during stage one of the Resident Quality Inspection showed the resident was using a restraint device

Review of the resident's care plan in Point Click Care showed that the restraint was part of the plan of care.

During an interview, Personal Support Worker (PSW), stated in part that the resident was unable to release the restraint and the restraint was being used for safety for the resident.

Interview was completed with a Registered Nurse (RN) who stated that the expectation of the home was that consent would be obtained for the use of the restraint.

The RN acknowledged that the consent for the restraints were to be kept on the resident’s hard copy chart and could not be produced.

Review of the plan of care for the resident showed the plan of care did not provide for everything required under subsection 3 for the use of restraints, specifically the resident was not assessed.

In an interview with Director of Care (DOC), DOC stated that the resident should have had a restraint assessment completed but the assessment was not completed, and alternatives had not been tried.

The licensee has failed to ensure The restraining of a resident by a physical device was included in a resident’s plan of care only if all of the following were satisfied: 2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 5. The restraining of the resident had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent. 6. The plan of care provides for everything required under subsection (3). [s. 31. (2)]

3. The licensee has failed to ensure that restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 2. Alternatives to restraining the resident has been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk.

A resident was observed on two separate days that showed that the resident was using a restraint device.

Care plan for the resident included a statement that the alternative restraint assessment form was discussed with the resident. An alternatives restraint assessment form was not included in the resident clinical record and was not available during the RQI.

RN said that alternatives to the use of a restraint for the resident had not been completed. RN said that they could not find evidence that an assessment for alternatives to a restraining device was completed.

DOC said it was the expectation of the home that an alternatives assessment for use of a restraining device would be completed prior to use of a restraint.

The licensee has failed to ensure that alternatives to restraining the resident were considered prior to use of the restraint. [s. 31. (2) 2.]

4. The licensee has failed to ensure the restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

A Resident was observed on two separate days using a restraint device.

During a staff interview, two RN's and one PSW told the Inspector that the resident was not able to release themselves from the restraint.

The clinical record for the resident did not include a physician's order for use of the restraint device and the RN said that the physician's order for use of the restraint had "likely" not been carried forward from one physician medication and treatment review to another.

DOC said that all active physician orders including use of a restraint device, should be

carried forward with each physician's medication and treatment review.

The licensee failed to ensure that the plan of care for the resident included a physician's order for use of a restraint device.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 14, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_259520_0012. [s. 31. (2) 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 alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk.The restraining of the resident 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. Physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining and that consent would be obtained and the plan of care provides for everything required in subsection (3), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that if there was no Family Council, the licensee convened semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

During an interview the Director of Activities stated that the licensee was not able to establish a Family Council President in the home and that the home had been advertising to have a family member join the council but no one was interested at that time.

Further interview with the Director of Activities stated that the licensee was not holding semi-annual meetings for Family Council and that the last Family Council meeting for the home was held in 2015.

The Administrator acknowledged that the licensee was not holding semi-annual Family Council meetings and should have been.

The licensee has failed to ensure that semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council when there was no active Family Council.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 59. (7) (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 that if there is no Family Council, the licensee shall convene semi-annual meetings to advise residents, families and persons of importance to residents of the right to establish a Family Council, to be implemented voluntarily.

WN #3: 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 an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

During the RQI, three residents were observed using physical devices that had restraining qualities.

The Inspector requested the monthly audits from the DOC for physical restraints that residents were using that had restraining qualities.

The home's Physical Restraint policy revised March 5, 2015, showed that a monthly analysis of resident restraints requirements would be discussed at the monthly meetings.

During an interview the DOC said that the home was not meeting monthly to review the physical restraint usage in the home and to complete the monthly analysis of the residents that were restrained.

The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 113. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and that all medication incidents were reported the pharmacy service provider.

A) A review of a medication incident which occurred involving a resident showed the resident did not receive a medication as prescribed by the physician.

Further review showed that there was no documented evidence of actions taken to assess and maintain the resident's health after the omission of the medication.

During an interview RPN, stated that they were the RPN who discovered the medication incident involving a resident . The RPN further said that an assessment to maintain the resident's health should have been completed after the medication incident was

discovered. RPN could not show documented evidence of the steps that were taken to assess and maintain the resident health.

During an interview the Director of Care (DOC) stated that actions taken to assess and maintain the resident health should have been documented and were not.

B) Review of separate medication incidents involving three resident's showed only one of the medication incidents had a faxed stamp which showed if the medication incident had been faxed to the pharmacy service provider.

During an interview a Registered Practical Nurse said that the expectation was that all medication incidents were faxed to the pharmacy provider and the medication incident report would be stamped to show that that the pharmacy had been notified by fax.

Director of Care (DOC), stated that the pharmacy should be notified by fax of all medication incidents.

In an interview with the Pharmacy Consultant, they acknowledged that they were not aware of the medication incidents reports for two residents as they were not faxed by the home.

The licensee has failed to ensure that every medication incident which involves a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and that all medication incidents were reported the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Review of the home's medication incident forms for the last medication quarterly review showed 13 medication incidents had occurred.

Review of the meeting minutes from the Professional Advisory Committee (PAC) meeting on August 23, 2017, did not show documented evidence of a review of all the medication incidents for the last medication quarterly review as the review was not completed.

Further review of the Medication Management Process which provided a quantitative incident and adverse analysis for Exeter Villa showed only five medication incidents had occurred in the second quarter.

During an interview the Director of Care said that the medication incidents were to be reviewed at Professional Advisory Committee (PAC). The last PAC meeting that was held the DOC stated they had attended. DOC further stated that the medication incidents which had occurred in the previous quarter were not quantitatively summarized and a full review with the purpose of reducing and preventing medication incidents had not occurred at the PAC meeting.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and that all medication incidents are reported to the pharmacy service provider and to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that has occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training had been provided for all direct care staff who applied physical devices or who monitored residents that were restrained by a physical device including: application, use and potential dangers of these physical devices.

Over a three day period the inspectors interviewed direct care staff who applied restraints to residents.The interviews showed that the staff did not have a good understanding of the assessment, planning, implementation, support and evaluation of the least restraint practices as well as the development of the individualized plan of care for the use of the restraint for residents.

During an interview with the Staff Educator they said that the front line staff were trained annually for Minimizing of Restraints and PASD's. The Staff Educator further said in September of this year, staff were to review and complete the minimizing of restraints and PASD's training manuals.

A review of the 2016 mandatory education training provided by the home to the direct care staff who would be applying physical restraints to residents showed that only 72 percent of the staff had completed the education on minimizing restraint's and PASD's for 2016.

The Administrator stated the expectation was that 100 percent of the staff that would be applying physical restraints to residents would be trained and had not received training in 2016.

The licensee has failed to ensure that training had been provided for all direct care staff who applied physical devices or who monitored residents that were restrained by a physical device, including; application, use, and potential dangers of these physical devices. [s. 221. (1) 5.]

2. The licensee has failed to ensure that training had been provided for all direct care staff who applied PASD's or who monitored residents with PASD's including; application, use and potential dangers of the PASD's.

Over three days the inspectors interviewed direct care staff who applied PASD's to residents.The interviews showed that the staff did not have a good understanding of the assessment, planning, implementation, support and evaluation of the least restraint practices as well as the development of the individualized plan of care for the use of the PASD's for residents.

Staff Educator said that the front line staff were trained annually for Minimizing of Restraints and PASD's. Staff Educator further said that this month, staff were to review and complete the minimizing of restraints and PASD's training.

A review of the 2016 mandatory education training provided by the home to the direct care staff who applied PASD's to residents showed that only 72 percent of the staff had completed the education on PASD's.

The Administrator stated the expectation was that 100 percent of the direct care staff that applied PASD's to residents would be trained and 28 percent of the staff had not received training in 2016.

The licensee has failed to ensure that training had been provided for all direct care staff that applied and monitored PASD's to residents

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 221. (1) 6.]

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 training had been provided for all direct care staff who apply physical devices and PASD's or who monitor residents that are restrained by a physical device and PASD's, including; application, use and potential dangers of these physical devices and PASD's, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of the PASD had been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

The Inspector completed observation on several days that showed a resident was using a restraint device.

A review of the resident's plan of care in Point Click Care (PCC) showed that there was no documentation that the SDM had been notified or that consent had been obtained for the use of the device.

The care plan for the resident showed that the resident required the device for activities of daily living (ADL).

The home's policy named Personal Assistance Services Device (PASD) revised March 5, 2015, stated in part that Mandatory Documentation was required in the Progress notes:

• Resident/SDM discussion regarding the use for the PASD
• Resident/SDM consent obtained

An interview conducted with the Registered Nurse (RN), stated that the resident's SDM should have consented for the use of the device and should have been informed that alternatives had been trialed, as well as any benefits associated with the PASD and any risks.

A review of the resident's health care record (HCR) in the paper chart kept at the nurse's station showed that there was no consent for the use of the PASD.

The RN said that the resident did not have consent for the use of the PASD from their SDM.

The DOC said that the resident's was using the devise as used as a PASD, and that they had not obtained consent from the SDM for the use of the PASD.

The licensee has failed to ensure that the use of the PASD was consented by the SDM and failed to ensure that the PASD, which was used to assist a resident with a routine activity of living was included in the residents' plan of care.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 33. (4) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection for residents and took immediate action as required.

Review of the resident health care record showed that the resident had symptoms of infection.

In an interview the Registered Nurse (RN) stated that the expectation was that the staff would record symptoms of infection in the resident's electronic progress notes.The RN reviewed the resident's progress notes and said that there was no recorded documentation of the resident symptoms of infection on every shift.

An Inspector interviewed the DOC who said that the expectation of the home was that staff would document and record all residents signs and symptoms of infection in the residents progress notes in PCC.

The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 229. (5) (b)]

Issued on this 9th day of November, 2017

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

Original report signed by the inspector.