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

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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
Nov 9, 2015	2015_248214_0021 (A1)	H-003276-15	Resident Quality Inspection

Licensee/Titulaire de permis

FOYER RICHELIEU WELLAND
655 Tanguay Ave WELLAND ON L3B 6A1

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

FOYER RICHELIEU WELLAND
655 TANGUAY AVENUE WELLAND ON L3B 6A1

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

CATHY FEDIASH (214), KELLY CHUCKRY (611)

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): September 22, 23, 24, 25, 28, 29, 30. October 1, 2, 6, and 7, 2015.

Please note: The following inspection's were conducted simultaneously with this RQI: Complaint inspection's H-001738-14, H-002267-15, H-002136-15, H-002229-15, H-003358-15; Critical Incident System inspection H-001732-14.

During the course of the inspection, the inspector(s) spoke with Chief Administration Officer, Director of Care (DOC), Finance Director, Kitchen Supervisor, Maintenance Supervisor, Resident Assessment Instrument (RAI) Coordinator, Foundation and Volunteer Coordinator, Administrative Assistant of Finance Director, Registered staff, Personal Support Workers (PSW), cook, resident's and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes and internal investigation notes; reviewed policies and procedures; observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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

9 WN(s)
7 VPC(s)
1 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) A review of resident #104's Minimum Data Set (MDS) coding for section M. Skin Condition completed on an identified date in 2015, indicated that the resident was coded as having alterations to their skin. A review of the narrative Resident Assessment

Protocol (RAP) for pressure ulcers completed on the same date, indicated that the resident had skin alterations to three identified areas on their body. An interview with registered staff on an identified date in 2015, indicated that the resident currently had alterations to their skin integrity to two identified areas on their body. A review of the Medication Administration Record (MAR) for treatments for an identified month in 2015, indicated to apply treatment to rash. An interview with the RAI Coordinator indicated that this treatment was for the alterations to the resident's skin integriy which was not a rash in nature. The RAI Coordinator confirmed that the treatment plan was not clear and had not set out clear directions to staff and others who provided direct care to the resident. (214)

B) A review of resident #110's clinical record indicated that following a return from a hospitalization on an identified date in 2015, the resident had identified alterations to their skin. A review of the current written plan of care for an identified period of time in 2015, indicated under interventions for ulceration or interference with structural integrity of layers of skin that the resident was receiving a nutritional supplement daily. A review of the same written plan of care under nutritional risk indicated that the resident was receiving a different identified nutritional supplement daily. A review of the clinical record indicated that on an identified date in 2015, the Registered Dietitian discontinued the initial nutritional supplement and ordered the second identified nutritional supplement daily. An interview with registered staff confirmed that the resident was ordered and was receiving the second identified nutritional supplement daily and that the plan of care had not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) A review of the Risk Management document used by the home to track incidents indicated that resident #102 sustained a fall on an identified date in 2015. A review of the notes section in Risk Management indicated that the falls prevention committee reviewed this fall and noted that the resident had declined in their mobility and was currently using a wheelchair. A review of the RAP for Falls that was completed on an identified date in 2015, indicated that the resident had decreased mobility and used a rollator walker for their mobility. A review of the resident's progress notes indicated that the Physiotherapist completed a Physiotherapy re-assessment note on an identified date

in 2015, which indicated that the resident currently needed a wheelchair for their safe mobility. An interview with front line nursing staff indicated that the resident no longer used their rollator walker and used a wheelchair for all of their mobility needs. An interview with the RAI Coordinator confirmed that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. (214)

B) A review of the Risk Management document used by the home to track incidents indicated that resident #102 sustained a fall on an identified date in 2015. A review of the Fall Risk Assessment that was completed on the same date of the fall indicated that the resident was assessed as a low risk for falls. A review of the RAP for Falls that was completed seven days later indicated that the resident was assessed as a moderate risk for falls. An interview with the RAI Coordinator confirmed staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. (214)

C) A review of the Risk Management document used by the home to track incidents indicated that resident #103 sustained a fall on an identified date in 2015. A review of the Fall Risk Assessment that was completed for this fall indicated that the resident was a low risk for falling and had no history of falling within the last six months. A review of the Risk Management document's and the resident's progress notes indicated that the resident had sustained a fall within the last six months on an identified date in 2015. An interview with the RAI Coordinator confirmed that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. [s. 6. (4) (a)]

3. 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 the initial tour of the home conducted on an identified date in 2015, resident #100 was found sitting on the toilet in a communal washroom unattended. The care plan for this resident indicated that the resident was to receive total assistance for toileting for the entire performance of this activity to ensure safety.

An identified staff member indicated they were aware the resident was in the washroom. The Director of Care confirmed that if the care plan indicates resident is not to be left unattended for toileting that is the level of assistance staff must provide. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A) A pain assessment was completed on an identified date in 2015, for resident #103 indicating that this resident was experiencing moderate pain daily. A subsequent pain assessment was completed on an identified date in 2015 indicating that resident #103 was experiencing severe pain daily.

Resident #103's written plan of care was not updated when there was a change in care needs. The RAI Coordinator confirmed the written plan of care was not updated to include the change in resident #103's care needs. (611)

B) A review of resident #102's current written plan of care indicated under the falls focus that the resident was at risk for falls and to ensure that their walker was in reach at all times. The written plan indicated under transferring to teach the resident to transfer with assistance of a rollator walker. The written plan indicated under mobility that the resident used a walker; staff to ensure the walker is nearby and that the resident used a wheelchair to and from the dining room when necessary. A review of the notes section in the Risk Management incident that was completed following a fall sustained by the resident on an identified date in 2015, indicated that the falls prevention committee reviewed this fall and noted that the resident declined in their mobility and is currently using a wheelchair. An interview with front line nursing staff indicated that the resident no longer used their rollator walker and used a wheelchair for all of their mobility needs. An interview with the RAI Coordinator confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (214)

C) A review of the Risk Management documents used by the home to track incident's indicated that resident #103 sustained falls on two identified dates in 2015. A review of the resident's written plan of care indicated that no plan was in place to manage this resident's risk for falls. An interview with the RAI Coordinator confirmed that the resident's plan of care had not been reviewed and revised following their last two falls as the plan to manage the resident's falls had been resolved. (214)

D) A review of resident #106's current written plan of care indicated that the resident was at risk for falling. A review of the resident's progress notes indicated that on an identified date in 2015, the Occupational Therapist conducted a follow up visit regarding equipment that the resident had recently received. A review of the residents current

written plan of care indicated under the falls focus that staff were to encourage the resident to use their walker at all times. An interview with the RAI Coordinator indicated that the resident was now using their rollator walker for short distances and was using a wheelchair for greater distances. The RAI Coordinator confirmed that the resident's plan of care had not identified the resident's use of their wheelchair and had not been reviewed and revised when the resident's care needs changed. (214)

E) A review of resident #107's progress notes indicated that on an identified date in 2015, the resident began to decline physically. A progress note completed by the Physiotherapist indicated that the resident had shown a significant decline in overall condition and that the use of specialized equipment would be discontinued. A review of the resident's progress notes indicated that on an identified date in 2015, the resident`s physician was notified of the resident`s continued decline in general condition and orders were received to discontinue all oral medications. A review of the resident`s clinical record indicated that the resident passed away on an identified date in 2015. A review of the residents written plan of care during this time period indicated under transferring that the resident was using the specialized equipment. The plan also indicated that staff was to administer an oral medication as ordered and the plan also indicated that staff were to encourage the resident to foot propel their own wheelchair. An interview with the RAI Coordinator confirmed that the resident had declined in their overall condition; had been cared for in bed; did not use the specialized equipment and that all oral medications had been discontinued. The RAI Coordinator confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed. (214)

F) A review of resident #109`s MDS coding for section I. Disease Diagnoses and dated with an identified date in 2015, indicated that the resident was coded as having a respiratory infection. The coding for section G. Physical Functioning and Structural Problems dated the same date indicated that the resident had deteriorated as compared to their status 90 days prior and required extensive assistance of one staff for bed mobility; required extensive assistance of one staff for transferring and required extensive assistance of one staff for dressing. The narrative RAP that was completed on the same date indicated that the resident required increased assistance with their transferring, bed mobility and dressing due to a respiratory illness. A review of the resident`s written plan of care in place during the time of this respiratory infection indicated under bed mobility that the resident was independent. The written plan under transferring indicated that the resident transferred without assistance and the written plan under dressing indicated that the resident required limited assistance with this task. An interview with the DOC confirmed that the resident`s plan of care was not reviewed and

revised during the time of their respiratory infection when their care needs changed. (214)

G) A review of resident #110's clinical record indicated that following a return from a hospitalization on an identified date in 2015, the resident had identified alterations to their skin. A review of the current written plan of care for an identified period of time in 2015, indicated under interventions for ulceration or interference with structural integrity of layers of skin to ensure that a non-medicated treatment was in place when the resident was sitting. A review of the clinical record indicated that on an identified date in 2015, a skin assessment was completed and indicated to discontinue the use of the non-medicated treatment. An interview with the RAI Coordinator confirmed that the resident's plan of care was not reviewed and revised when the resident's needs changed. (214) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written plan of care for each resident that set's out clear directions to staff and others who provide direct care to the resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

1. The home has a policy in place titled "Pain Management", (Document #07-00-12) that was revised December 2014. This policy indicated the following:

i) that if pain is identified as a problem for a resident on the comprehensive assessment, and scores two (2) or greater on the PAIN outcome measure scale following completion of the RAI-MDS 2.0 then a written plan of care is to be initiated within 24 hours.

ii) Residents requiring PRN pain medication are to be assessed using the numeric rating scale or the PAINAD tool. In addition, the policy indicates that residents are to be reassessed using the same scale and if the pain medication is ineffective, the RN is to be consulted.

A) A pain assessment was completed for resident #103 in Point Click Care (PCC) on an identified date in 2015. This assessment indicated that the resident was experiencing severe pain daily. On an earlier identified date in 2015, an annual assessment was completed for this resident with the PAIN outcome score was identified as a two (2). Resident #103 did not have a written plan of care initiated.

For an identified period of two months in 2015, resident #103 required PRN medication a total of 76 times. The numeric tool was determined to be appropriate for this resident. The assessment tool prior to the administration of the prescribed analgesic was completed 17/76 times. When reassessing the effectiveness of the PRN medication, the

assessment tool was used 7/76 times.

B) A pain assessment was completed for resident #110 in Point Click Care (PCC) on an identified date in 2015. This assessment indicated that the resident was experiencing moderate pain daily. On the same date, an MDS assessment was completed for this resident with the PAIN outcome score being identified as a two (2). Resident #110 did not have a written plan of care initiated.

For an identified period of one month in 2015, resident #110 required PRN medication a total of 24 times. The pain assessment tool was not consistently used when reassessing the effectiveness of the PRN medication.

The above noted policy was not complied with for resident #103 and #110. An interview with the DOC and RAI Coordinator confirmed this. (611)

2. A review of resident #104's MDS coding for section M. Skin Condition with an identified completion date in 2015, indicated that the resident was coded as having two areas of alterations to their skin integrity. A review of the narrative RAP for pressure ulcers completed on the same date indicated that the resident had skin alterations to three identified areas on their body. An interview with registered staff on an identified date in 2015, indicated that the resident currently had alterations to their skin integrity to two identified areas on their body. A review of skin assessments completed for the resident's skin alterations for an identified period of time in 2015, indicated that Pressure Ulcer/Wound Assessments completed on five identified dates in 2015, had been combined to include assessment of the altered skin areas to two identified areas on the resident's body.

An interview with the DOC confirmed that when a resident has more than one area of altered skin integrity, it is the home's protocol that each area of altered skin integrity be assessed individually and not combined on one assessment. The DOC confirmed that the home had not complied with their wound/skin care protocol. (214)

3. A review of the home's policy titled, Skin and Wound Care Management (with a revision date of June 2012) indicated the following:

i) If a resident is admitted with skin breakdown or skin breakdown develops, the registered staff must initiate the initial wound assessment on Point Click Care (PCC).

A review of resident #110's clinical record indicated that the when the resident returned from a hospitalization on an identified date in 2015, the resident had identified wounds to their skin. A review of the initial wound assessment indicated that the assessment was completed using the Weekly Treatment Skin Assessment and not the Pressure Ulcer/Wound Assessment. An interview with the RAI Coordinator confirmed that the home had completed the initial wound assessment using the Weekly Treatment Skin Assessment which was not designed for wound assessments and that the home had not complied with their policy. (214) [s. 8. (1) (a),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 that any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

An initial tour of the home was conducted on an identified date in 2015. During this tour, a window in the television room near the entrance of the building had a window that opened in excess of 15 centimetres. This poses a potential risk to residents living in the home. The Chief Administrative Officer confirmed this, and took immediate steps to rectify the situation. [s. 16.]

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 window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of the home's policy titled, Resident Abuse: Witnessing and Reporting (09-04-04 with a revision date of December 2014) indicated the following:

i) The employee is expected to report abuse to the appropriate Foyer Richelieu Welland authority, i.e., RN, RPN, Director of Care, Administrator.

ii) If actions taken are thought to be inappropriate or inadequate, report the incident and the response to the Director of Care.

A review of a Critical Incident System (CIS) that was completed by the home indicated that on an identified date in 2014, resident #200 was inappropriately placed into a seated position in their wheelchair by a staff member, held and then restrained in their wheelchair. An interview with the DOC confirmed that this incident was initially reported to a representative of the home's Health and Safety committee the following morning and was not reported to the Chief Administrative Officer or the DOC until later this same day. The DOC confirmed that home had not complied with their written policy to promote zero tolerance of abuse and neglect of residents.

(PLEASE NOTE: The above noted non-compliance was identified while conducting a concurrent
Critical Incident System Log # H-001732-14). [s. 20. (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 that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of resident #105's RAP for pressure ulcers completed on an identified date in 2015, and a review of skin/wound progress notes in the resident's clinical record indicated that on an identified date in 2015, the resident had an identified area of skin alteration to their body. A review of the resident's clinical record indicated that a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, was not completed for the resident's altered skin integrity. An interview with the RAI Coordinator confirmed that this assessment had not been completed. (214)

B) A review of resident #110's clinical record indicated that an Altered skin integrity assessment was completed on an identified date in 2015, for an identified area of skin alteration on their body. This assessment indicated that this was the initial assessment and that the pressure ulcer had been acquired on a specific date in 2015. A review of the resident's clinical record indicated that no assessments were completed when the resident exhibited the pressure ulcer on this specified date in 2015. An interview with the RAI Coordinator confirmed that when the resident exhibited an identified area of skin alteration, they did not receive a skin assessment that was specifically designed for skin and wound assessments, until 6 days later. [s. 50. (2) (b) (i)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #105's RAP for pressure ulcers with an identified completion date in 2015, and a review of skin/wound progress notes in the resident's clinical record with an identified date in 2015, indicated that the resident had an alteration to their skin integrity on an identified area of their body. A review of the resident's Medication Administration Record (MAR) for treatments indicated that the identified alteration of skin integrity healed on a specified date in 2015. A review of the resident's clinical record and confirmed by the RAI Coordinator indicated that no weekly re-assessments of the resident's pressure ulcer had been completed by a member of the registered nursing staff. (214) [s. 50. (2) (b) (iv)]

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, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the pain management program included monitoring responses to, and the effectiveness of, the pain management strategies.

A) Resident #102 had an order in place to receive an analgesic for pain as required (PRN). This resident received this medication for pain on two identified dates in 2015. The effectiveness of this pain medication was not evaluated. An interview with the DOC and RAI Coordinator confirmed the homes expectation is to document PRN pain medication effectiveness on the back of the Medication Administration Record (MAR) or progress notes and this was not completed.

B) Resident #103 had two separate orders in place to receive analgesics for pain as required (PRN). For an identified period of two months in 2015, the resident received PRN analgesia a total of 76 times. The home's expectation is to evaluate the effectiveness of PRN pain medication using either a numeric rating scale, or a PAINAD tool. A numeric rating scale was determined to be appropriate for this resident; however; was only used 7/76 times to monitor the effectiveness of the pain management strategy. An interview with the DOC and RAI Coordinator confirmed the expectations of the home were not complied with.

C) Resident #110 had an order in place to receive analgesics for pain as required (PRN) per the medical directive. For an identified period of time of one month in 2015, the resident received PRN analgesia a total of 24 times. The home's expectation is to evaluate the effectiveness of PRN pain medication using either a numeric rating scale, or a PAINAD tool. This tool was not consistently used to monitor the effectiveness of the pain management strategy. An interview with the RAI Coordinator confirmed the expectations of the home were not complied with. [s. 52. (1) 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 the pain management program includes monitoring responses to, and the effectiveness of, the pain management strategies, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

An initial tour was conducted of the home on an identified date in 2015. During this tour, a room labelled "salle de bain" was unlocked and contained a hazardous substance, specifically RX 44. This substance is identified as a corrosive material and is a class E substance. In addition, a second room labelled "salle de bain et douche" was unlocked and contained numerous containers of Isagel, which is a class B substance and is identified as flammable and combustible. Both rooms were accessible to residents. An interview with a registered staff member confirmed these doors should be locked when not in use. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: 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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to 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: 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.

A) An annual program evaluation was completed with respect to the home's pain management program for 2014. This program evaluation did not include a summary of

the changed made and the date those changes were implemented. The DOC confirmed this information was not captured during the annual program evaluation. (611)

B) A review of the home's annual program evaluation for the Falls Prevention and Management Program 2014 indicated the date of the evaluation and the names of the persons who participated in the evaluation as well as a summary of changes made; however; had not included the date that any changes were implemented. An interview with the Director of Care confirmed that the annual program evaluation had not included all of the required information. (214)

C) An annual program evaluation was completed with respect to the home's responsive behaviour program for 2014. This program evaluation did not include a summary of the changes made and the date those changes were implemented. The DOC confirmed this information was not captured during this annual program evaluation. (611)

D) A review of the home's annual program evaluation for the Skin and Wound Care Program 2014 indicated the date of the evaluation and the names of the persons who participated in the evaluation; however; had not included a summary of changes made or the date that any changes were implemented. An interview with the Director of Care confirmed that the annual program evaluation had not included all of the required information. (214) [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #102's current written plan of care indicated that the resident was at risk for falls. Interventions to manage this risk indicated that staff was to check the resident every two hours to ensure their safety. A review of this task in the Point of Care (POC) documentation system for three consecutive dates in 2015, indicated that on the first date the resident was documented as being checked at 1334 hours and not again until 1729 hours. On the same date, the resident was documented as being checked at 2129 hours and not again until the next day at 0124 hours. A review of the second date indicated that the resident was documented as being checked at 2141 hours and not again until the following day at 0152 hours. On this same date, documentation indicated that the resident was checked at 0504 hours and not again until 0915 hours. An interview with the RAI Coordinator confirmed that the resident was checked every two hours; however; these actions were not documented. (214) [s. 30. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Upon review of the Residents' Council minutes, concerns were identified in the minutes of a specified meeting in 2015. Specifically, the minutes identified concerns with cooked vegetables, the temperature of the food, and the temperature of the coffee. The Foundation and Volunteer Co-ordinator confirmed the concerns were immediately followed up on, but were not responded to in writing within ten (10) days of receiving these concerns. It was further identified the home does not have a process in place to respond in writing to any concerns or recommendations made by Residents' Council. [s. 57. (2)]

Issued on this 12th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHY FEDIASH (214), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2015_248214_0021
Log No. / Registre no:	H-003276-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 9, 2015
Licensee / Titulaire de permis :	FOYER RICHELIEU WELLAND 655 Tanguay Ave, WELLAND, ON, L3B-6A1
LTC Home / Foyer de SLD :	FOYER RICHELIEU WELLAND 655 TANGUAY AVENUE, WELLAND, ON, L3B-6A1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SEAN KEAYS

To FOYER RICHELIEU WELLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that all residents including residents #102, 103, 106, 109 and 110 are reassessed and their plan of care reviewed and revised at least every six months and at any other time when the residents care needs change or care set out in the plan is no longer necessary, including but not limited to reviewing and revising changes in the following areas:

Skin and Wound Care;
Falls prevention and management;
Pain;
Hospitalization and Change in Condition.

Grounds / Motifs :

1. A) Previously identified as non-compliant with a VPC on November 18, 2014.

B) A review of resident #102's current written plan of care indicated under the falls focus that the resident was at risk for falls and to ensure that their walker was in reach at all times. The written plan indicated under transferring to teach the resident to transfer with assistance of a rollator walker. The written plan indicated under mobility that the resident used a walker; staff to ensure the walker is nearby and that the resident used a wheelchair to and from the dining room when necessary. A review of the notes section in the Risk Management incident that was completed following a fall sustained by the resident on an

identified date in 2015, indicated that the falls prevention committee reviewed this fall and noted that the resident declined in their mobility and is currently using a wheelchair. An interview with front line nursing staff indicated that the resident no longer used their rollator walker and used a wheelchair for all of their mobility needs. An interview with the RAI Coordinator confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. (214)

C) A pain assessment was completed on an identified date in 2015 for resident #103 indicating that this resident was experiencing moderate pain daily. A subsequent pain assessment was completed on an identified date in 2015 indicating that resident #103 was experiencing severe pain daily. Resident #103's written plan of care was not updated when there was a change in care needs. The RAI Coordinator confirmed the written plan of care was not updated to include the change in resident #103's care needs. (611)

D) A review of resident #107's progress notes indicated that on an identified date in 2015, the resident began to decline physically. A progress note completed by the Physiotherapist indicated that the resident had shown a significant decline in overall condition and that the use of specialized equipment would be discontinued. A review of the resident's progress notes indicated that on an identified date in 2015, the resident`s physician was notified of the resident`s continued decline in general condition and orders were received to discontinue all oral medications. A review of the resident`s clinical record indicated that the resident passed away on an identified date. A review of the residents written plan of care during this time period indicated under transferring that the resident was using the specialized equipment. The plan also indicated that staff was to administer an oral medication as ordered and the plan also indicated that staff were to encourage the resident to foot propel their own wheelchair. An interview with the RAI Coordinator confirmed that the resident had declined in their overall condition; had been cared for in bed; did not use the specialized equipment and that all oral medications had been discontinued. The RAI Coordinator confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed. (214)

E) A review of the Risk Management documents used by the home to track incident's indicated that resident #103 sustained falls on two identified dates in 2015. A review of the resident's written plan of care indicated that no plan was in place to manage this resident's risk for falls. An interview with the RAI

Coordinator confirmed that the resident's plan of care had not been reviewed and revised following their last two falls as the plan to manage the resident's falls had been resolved. (214)

F) A review of resident #106's current written plan of care indicated that the resident was at risk for falling. A review of the resident's progress notes indicated that on an identified date in 2015, the Occupational Therapist conducted a follow up visit regarding equipment that the resident had recently received. A review of the residents current written plan of care indicated under the falls focus that staff were to encourage the resident to use their walker at all times. An interview with the RAI Coordinator indicated that the resident was now using their rollator walker for short distances and was using a wheelchair for greater distances. The RAI Coordinator confirmed that the resident's plan of care had not identified the resident's use of their wheelchair and had not been reviewed and revised when the resident's care needs changed. (214)

G) A review of resident # 109`s Minimum Data Set (MDS) coding for section I. Disease Diagnoses with an identified date in 2015, indicated that the resident was coded as having a respiratory infection. The coding for section G. Physical Functioning and Structural Problems dated the same date, indicated that the resident had deteriorated as compared to their status 90 days prior and required extensive assistance of one staff for bed mobility; required extensive assistance of one staff for transferring and required extensive assistance of one staff for dressing. The narrative Resident Assessment Protocol (RAP) that was completed on the same date, indicated that the resident required increased assistance with their transferring, bed mobility and dressing due to a respiratory illness. A review of the resident`s written plan of care in place during the time of this respiratory infection indicated under bed mobility that the resident was independent. The written plan under transferring indicated that the resident transferred without assistance and the written plan under dressing indicated that the resident required limited assistance with this task. An interview with the DOC confirmed that the resident`s plan of care was not reviewed and revised during the time of their respiratory infection when their care needs changed. (214)

H) A review of resident #110's clinical record indicated that following a return from a hospitalization on an identified date in 2015, the resident had identified alterations to their skin. A review of the current written plan of care for an identified period of time in 2015, indicated under interventions for ulceration or

interference with structural integrity of layers of skin to ensure that a non-medicated treatment was in place when the resident was sitting. A review of the clinical record indicated that on an identified date in 2015, a skin assessment was completed and indicated to discontinue the use of the non-medicated treatment. An interview with the RAI Coordinator confirmed that the resident's plan of care was not reviewed and revised when the resident's needs changed. (214)

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

Service Area Office /
Bureau régional de services : Hamilton Service Area Office