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
Mar 4, 2016	2016_384161_0006	003327-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

KATHLEEN SMID (161), AMANDA NIXON (148), GILLIAN CHAMBERLIN (593), RENA BOWEN (549)

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): February 17, 18, 19, 22, 23, 24, 25, 26, 2016.

During the course of the Resident Quality Inspection, the inspector(s) also conducted nine concurrent inspections which included:

- six Critical Incident inspections: log #003795-15 related to alleged resident to resident physical abuse; log #035560-15, log #001532-16 related to alleged staff to resident abuse; log #004742-15, log #005412-15 and log #031835-15 related to residents who fell which resulted in transfer to a hospital,

- two Complaint inspections: log #022848-15 related to medication and log #029972-15 related to the provision of care to an identified resident,

- one Follow-up to a compliance order inspection: log #035890-15 issued on December 22, 2015 under inspection #2015_384161_0020 related to an identified resident's plan of care.

During the course of the inspection, the inspector(s) spoke with residents, family members, President of Resident Council, President of Family Council, Housekeepers, Personal Support Workers (PSW), RAI Coordinator, Registered Practical Nurses (RPN), Registered Nurses (RN), Clinical Coordinator, Maintenance/Environmental Services Manager, Life Enrichment Coordinator, Resident Service Coordinator, Assistant Director of Care, Director of Care (DOC) and the home's Administrator.

During the course of the inspection, the inspector(s) observed the delivery of resident care and services, resident rooms, resident common areas, infection control practices, medication administration and two meal services. The inspector (s) reviewed residents' health care records, salient home policies and procedures, posted menus, staff work routines, Resident Council minutes and Family Council minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2015_384161_0020	161

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is assessed and their bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

According to the "Health Canada Guidance Document- Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards" dated March 17, 2008; reducing the risk of entrapment involves a multi-faceted approach that includes bed design, clinical assessment, and monitoring, as well as meeting patient, resident and family needs for vulnerable patients in most healthcare settings- hospitals, long-term care facilities, and at home. Therefore, comprehensive bed safety programs in these settings will likely involve input from manufacturers as well as facility staff. Recognizing that not all hospital beds present a risk of entrapment, and that this risk may vary depending upon the patient, Health Canada encourages manufacturers and facilities to work together to develop bed safety programs to evaluate and, if needed, mitigate entrapment risk. The end user should test any mattress for compatibility with the bed prior to use, to ensure the bed and mattress combination meets the recommendations of this guidance.

During an interview with Inspector #593, February 24, 2016, the home's DOC reported that there is a bed system evaluation undertaken annually within the home however residents and their use of the bed system were not considered during the evaluations. Furthermore, they reported that the home does not currently have a process in place to ensure that all residents with bed rails are assessed and that previously they have assessed residents with bilateral full bed rails only as these are considered restraints. The home has a new assessment tool that is going to be implemented soon, which will

ensure that all residents who use bed rails are assessed however, currently they do not have this information for all residents in the home that use bed rails.

During an interview with Inspector #593, February 26, 2016, the DOC reported that all beds in the home are fitted with bed rails, and that each bed either has bilateral full bed rails or assist rails in place. They confirmed that all beds in the home have some form of bed rails in use presently however it depends upon the resident as to whether these are used and how they are used.

During an interview with Inspector #593, February 25, 2016, the Maintenance/Environmental Services Manager #117 reported that an external company comes into the home annually to complete assessments of the bed systems however the assessments do not include the resident or how the resident uses the bed system. [s. 15. (1) (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 bed systems are evaluated in accordance with evidence based practice, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

The licensee has failed to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A Critical Incident (CI) was submitted to the home on a specified date in January 2016, related to an incident where two PSW’s #122 and #123, put resident #052 in bed, raised both the head and the foot of the bed and left the room. The CI detailed that the head and the foot of the bed were elevated to the maximum as a form of restraint. RN #124 was walking down the corridor and heard the resident calling for help as the resident was essentially trapped in the bed. The resident reported that he/she was uncomfortable and wanted to roll onto his/her side. The RN reported that the resident was in a position that prevented him/her from rolling to his/her side or getting out of bed.

A review of the home’s investigation found a description of the events as reported by RN #124: PSW #122 assisted PSW #123 to put resident #052 to bed. The resident was agitated and aggressive and did not want to go to bed. PSW #122 raised the head and the foot of the bed before leaving the room at approximately 2315 hours. At 2340 hours, RN #124 was passing by the room when they heard the resident screaming for help. She

opened the door and saw the resident in an unusual position. The resident was trying to roll onto his/her back but was stuck. RN #124 reported that the bed alarm was not attached to the paging device and the door to the room was closed. PSW #123 reported to RN #124 that PSW #122 told her to elevate the foot of the bed so that the resident could not get out of bed. During the investigation, PSW #123 confirmed that PSW #122 told her to elevate the foot of the bed so that the resident could not get out of bed.

A review of resident #052’s care plan at the time of the incident, found that the resident was a high risk of falls and interventions included the use of a bed alarm when the resident was in bed to notify staff if he/she is trying to get out of bed without staff assistance.

During an interview with Inspector #593, February 26, 2016, the DOC reported that both PSW’s involved received a formal discipline as a result of this incident. PSW #123 reported during the investigation that she felt uncomfortable with the situation after they left the resident and was thinking about what to do, when RN #124 found the resident. The DOC further reported that they were investigating this as the use of an illegal restraint.

A review of the home’s policy titled “Least Restraint, Last Resort - CS-5.1” effective date April 2013, found that a restraint shall not be used under any of the following circumstances: because the resident cannot be adequately observe, to control any behaviour that is not a serious risk to the resident or others, before all appropriate alternatives have been considered or trialed, in a non-imminent situation without the consent of the residents SDM, for the convenience of staff or as a disciplinary measure.

A review of the home’s policy titled “Physical Restraints - CS-5.3” effective date January 2011, found that the following devices are approved for use in the home after all other alternatives have failed: Lap belt, lap tray, tilt chair.

As reported by RN #124 and PSW #123, resident #052 was purposely left in a position for approximately 25 minutes where the resident was unable to reposition themself or ambulate out of bed. Furthermore, it was reported by RN #124 that when they found the resident, the door was shut and their bed alarm was not attached to the paging device. The resident was restrained by the staff with the use of a physical device that was not in accordance with the Act or with the home’s physical restraint policy. [s. 30. (1) 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 no resident of the home is restrained unless in accordance with Section 31 or Section 36, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear direction to staff and others that provide direct care to the resident.

During the inspection, Inspector #593 observed resident #025’s bed system with either one half rail in the up position or bilateral bed rails in place as short assist rails.

During an interview with Inspector #593, February 19, 2016, resident #025 reported that he/she uses the bed rails once he/she is in bed for repositioning or for support when staff are assisting him/her with care.

During an interview with Inspector #593, February 19, 2016, RPN #116 reported that they were unsure about the reason for the use of bed rails for this resident but believed it may be for positioning. The RPN added that the bed rails for resident #025 are not

considered a restraint but would still need to be checked regularly by staff for safety.

During an interview with Inspector #593, February 24, 2016, PSW #114 reported that the resident uses the half rails at night time when in bed and was unsure if one or two half bed rails was used for this resident but believed it might be one. The PSW further reported that the bed rails were used for the resident’s safety and protection. The PSW reported that the bed rails were not in use during the day as the resident is never in bed during the day. The PSW further reported that this information should be located in the residents care plan.

During an interview with Inspector #593, February 24, 2016, RPN #115 reported that the use of the bed rails for this resident should be documented in the care plan. The RPN further reported that when a resident is admitted, they complete an assessment and this indicates whether the resident requires bed rails or not. If something changes, then they are to re-assess the resident for the use and need of bed rails.

A review of the admission assessment completed for this resident indicated: two half rails up for safety. A review of the residents care plan found no documentation related to the use of bed rails. A review of resident #025’s progress notes found two entries related to the use of bed rails:

"March 13, 2015- Confused this evening, climbing over half bed rail and walking down the hall holding the wall. Put on 15 minute security checks to monitor over the weekend.

March 16, 2015- Staff have found that resident #025’s memory is not stable so half size of bed rail should be put down in order to remind the resident to use the call bell when he/she needs to get up."

During an interview with Inspector #593, February 24, 2016, the DOC reported that previously they have only assessed residents with bilateral full bed rails as these are considered restraints. The home has a new assessment tool that is going to be implemented soon, which will ensure that all residents who use bed rails are assessed however currently they do not have this information for resident #025.

The DOC further reported that the use of bed rails for resident #025 should be documented in the care plan.

A review of the home’s policy titled "Least Restraint, Last Resort, Minimizing of

Restraints - CS-5.1” effective date April 2013, found that examples of Personal Assistive Service Devices (PASDs) are bed rails- used for comfort or to assist with bed mobility. The registered staff shall document each assessment and the outcome in the resident’s clinical record including if a PASD is deemed necessary, the type of device and the reason for its use. [s. 6. (1) (c)]

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

Resident #013 has a urine collection device and as indicated by the plan of care, is to be monitored for symptoms of urinary tract infections.

The Physician Medication Reviews from June 1, 2015 to February 29, 2016 indicate that the resident is to have a urine culture and sensitivity (C&S) completed monthly. Upon review of the health care record, Inspector #148 confirmed that a urine C&S was completed September 2015 and again in February 2016. Urine C&S for the months of October, November, December and January, could not be located.

The Inspector brought the above concern to the attention of the home’s ADOC. After speaking with the company that provides the home's laboratory services and the regular day nurse for resident #013’s unit, the ADOC confirmed that no urine C&S was completed for the months October 2015 through to January 2016. [s. 6. (7)]

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

A Critical Incident (CI) was submitted to the home on a specified date in January, 2016, related to an incident where two PSW’s #122 and #123, physically restrained resident #052 by the use of a physical device, other than accordance with section 31 or under the common law duty described in section 36.

A review of the home’s investigation found a description of the events as reported by RN #124: PSW #122 assisted PSW #123 to put resident #052 to bed. PSW #122 raised the head and the foot of the bed before leaving the room at approximately 2315h. At 2340h, RN #124 was passing by the room when they heard the resident screaming for help. She opened the door and saw the resident in an unusual position. The resident was trying to roll onto his/her back but was stuck. RN #124 reported that the bed alarm was not attached to the paging device and the door to the room was closed.

A review of resident #052's care plan at the time of the incident, found that the resident was a high risk of falls and interventions included the use of a bed alarm when he/she was in bed to notify staff if the resident was trying to get out of bed without staff assistance.

The licensee has failed to ensure that the use of a bed alarm while resident #052 was in bed, was provided to the resident as per the plan of care. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #020 has received grooming on a daily basis.

Resident #020 was observed with significant facial hair above the lip and on the chin during the inspection, from February 17, 2016 to February 23, 2016.

During an interview with Inspector #593, February 23, 2016, PSW #113 reported that for female residents with facial hair, they usually try to trim or shave this every two to three days. When asked specifically about resident #020, the PSW responded that they were going to shave her facial hair yesterday however they were unable to locate the electric shaver on the unit. PSW #113 further reported that when this task is completed, it is recorded on the PSW Observational Flow Sheets.

During an interview with Inspector #593, February 23, 2016, resident #020 reported that she liked to be kept groomed and required assistance from staff for this task and that she liked to have her facial hair shaved “about once per week”.

A review of resident #020’s current care plan, found that resident #020 is to be clean and well groomed by staff at all times and that she requires assistance for personal hygiene. There was however, no documented intervention related to grooming of facial hair for this resident.

A review of the PSW Observational Flow Sheets for resident #020 from a specified date in January 2016 to a specified date in late February 2016, found that the last shave documented for this resident was on a specified date in early January 2016 and every flow sheet since this date, was documented as task not completed for this resident.

A review of the home’s policy titled “Morning (AM) Care, Hygiene and Grooming - CS-13.1” effective date January 2011, found that appropriate care is provided to each resident every morning to ensure dignity and a sense of well-being. The procedure documents to trim facial hair of female residents as required and it is the responsibility of all nursing staff to ensure that morning care is provided in accordance with this procedure. [s. 32.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On February 24, 2016 at 0825 hours Inspector #161 observed 5 medicated creams in a small unlocked/unattended plastic box on the third floor west wing laundry cart located in the resident hallway. There were residents ambulating in the hallway on their way to the dining room. On February 25, 2016 at 0850 hours Inspector #161 observed 1 open bottle of Lactulose 500 ml on the top of the medication cart located in the first floor east dining room on the secure unit. The residents were in the dining room eating breakfast at that time and there was no registered staff member present. Several minutes later, Inspector #161 observed a registered staff member walk down the hallway and approach the medication cart. [s. 129. (1) (a)]

Issued on this 4th day of March, 2016

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

Original report signed by the inspector.