Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2019	2019_787640_0020	004561-19	Critical Incident System

Licensee/Titulaire de permis

Clurelea Ltd.
c/o Good Samaritan Nursing Home 481 Victoria Street East Alliston ON L9R 1J8

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

Good Samaritan Nursing Home
481 Victoria Street East Alliston ON L9R 1J8

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 25, 26 and 27, 2019.

During the course of the inspection, the Inspector toured the home, observed the provision of care, reviewed clinical records, policy and procedure and conducted interviews.

The following Critical Incident reports were reviewed:

Log #004561-19, related to a fall and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision-makers, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Care Planning Coordinator and the Administrator/Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Minimizing of Restraining
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **3 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	Légende 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #001, #002, #003 and #004 had a post fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) On an identified date in February 2019, resident #001 had an unwitnessed fall. On a second date in February 2019, the resident had another unwitnessed fall. Two days following this fall, the resident's condition declined.

Following both falls, nursing staff completed a "Resident Incident Report" that included a section for the description of the incident, assessment findings and notification of the physician.

The licensee's policy "Fall Prevention and Management" with an effective date of April 2019, directed staff to complete a resident incident form and the post fall screening form related to environmental factors. For those residents with three or more falls in a one-month period, a "Fall Incident Assessment" form was to be completed to guide future fall prevention, following which staff were to conduct an interdisciplinary conference to discuss the falls.

The home's policy "Guidelines for Completing Incident Forms" with an effective date of June 2, 1988, directed staff to:

- note description of resident including ambulation and normal habits,
- note the sequence of events including where and how the incident happened, was it witnessed and resident's perception,
- note staff action and preventive measures such as assessment protocol followed, treatment given and preventive measures and,
- note staffing conditions - number of nursing staff and deployment at the time of the incident (eg. bath or meal time)

RPN #102 told the Long-Term Care Homes (LTCH) Inspector when a resident had fallen, staff completed the "Resident Incident Report" and the "Post Fall Screening Assessment/checklist which included environmental/resident issues related to room clutter, lighting and footwear. The RPN said when a resident had three or more falls in a month, then a more complex form, "Post Fall Incident Assessment" was to be completed.

b) On an identified date in April 2019, resident #002 had an unwitnessed fall. Nursing staff completed a "Resident Incident Report" that included a section for the description of the incident, assessment findings and notification of the physician and the "Post Fall Screeniing" tool.

c) On an identified date in April 2019, resident #003 had an unwitnessed fall. Nursing staff completed a "Resident Incident Report" that included a section for the description of the incident, assessment findings and notification of the physician and the "Post Fall Screen" tool.

d) The Resident Incident Forms indicated that resident #004 fell on two identified dates in April 2019, with no signs of injury for either fall.

The Administrator/DOC told the LTCH Inspector that the resident incident forms were not clinically appropriate for the assessment of falls and was not based on evidence-based and prevailing practice. The incident form was a generic form to document any type of incident or accident. They were not able to provide evidence of the best-practice for post fall assessments.

The licensee failed to ensure that resident's who had fallen were assessed using a clinically appropriate assessment instrument specifically designed for the assessment of falls. [s. 49. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #003 and #005 who were dependent on staff for repositioning, were repositioned every two hours or more frequently as required.

a) Resident #003 had specialized equipment implemented as a personal assistance services device (PASD) for comfort and safety.

The plan of care directed staff to change the resident's position frequently, regularly and as per the turning program.

RN #104 told the LTCH Inspector that the specialized equipment was implemented for comfort and safety. They were not able to get themselves out of the specialized equipment without assistance of staff. Resident #003 was on the turning program.

Personal Support Worker (PSW) #105 told the LTCH Inspector that any resident using the specialized equipment only needed to be repositioned if they had any skin issues. At that time, they would be repositioned every two hours and documented on the "turning form".

The LTCH Inspector reviewed the clinical record, specifically the "Turning/Change of Position Schedule" form for the month of June 2019.

Ten of the 70 entries, included a check mark for the side the resident was placed on or that they were put to bed. The remaining days were a variety of documentation not all related to repositioning of the resident.

RN #104 said that staff were required to turn or reposition resident #003 every 2 hours and document the intervention on the turning schedule form.

b) Resident #005 had specialized equipment implemented for comfort, safety and to offload pressure.

Resident #005's plan of care directed staff to assist the resident with turning while in bed and implement the turning program.

RN #104 and RPN #102 told the LTCH Inspector that the specialized equipment was implemented for comfort and safety. Resident #005 was on the turning program and that staff were required to turn or reposition the resident every two hours and document the intervention on the turning schedule form.

PSW #111 told the LTCH Inspector that resident #005 only required turning and repositioning during the night. The resident used the specialized equipment all day so staff did not have to do the turning and repositioning.

The LTCH Inspector reviewed the clinical record, specifically the "Turning/Change of Position Schedule" form for a period of time in June 2019.

The documented dates contained notes that the resident had been repositioned. All times documented were for the night shift only. There was no pattern to the timing of the repositioning that occurred from every two- and one-half hours to three hours and on six of the eight dates, the resident was repositioned twice during the eight-hour night shift.

RN #104 acknowledged that staff had not complied with the turning program as the documentation on the turning schedule form had demonstrated, for residents #003 and #005. They said that staff were required to turn and reposition residents #003 and #005 every two hours and based on what the PSWs had told the LTCH Inspector, they had not been implementing the turning program as required. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

a) Resident #003 was assessed to be incontinent of bowel and bladder.

The toileting documentation sheet that was supposed to be used when staff took the resident to the toilet, was blank.

RN #104 told the LTCH Inspector the home did not do a specific observation period of residents to determine their toileting patterns and there were no individualized toileting plans developed for any resident.

RN #106 and PSWs #107 and #108 said they did not have any individualized toileting plans for any resident. They used their "change list" and went room by room.

b) Resident #004 was assessed to be continent of bowel and incontinent of bladder.

The resident's plan of care directed staff to toilet them regularly.

The clinical record was reviewed and the PSW documentation record/flow sheet for a period of 26 days. The documentation on the flow sheets identified the resident was infrequently taken to the toilet.

c) Resident #005 was assessed to be continent of bowel and incontinent of bladder.

The resident's plan of care directed staff to toilet the resident regularly.

The LTCH Inspector reviewed the "Toileting Documentation" form for an 11 day period which identified infrequent toileting.

All documented dates contained documentation that the resident had been repositioned. All times documented were for the night shift only. There was no pattern.

The licensee failed to ensure that residents who were incontinent had an individualized plan to manage their bladder and bowel continence. [s. 51. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003's specified care was provided as set out in their plan of care.

Resident #003 had multiple falls. The use of safety equipment was initiated.

On an identified date in April 2019, the resident had an unwitnessed fall. The incident report noted the resident was not wearing their safety equipment at the time.

The LTCH Inspector observed the resident on an identified date in June 2019, and they were not wearing their safety equipment.

During an interview with PSW #108 regarding fall prevention interventions and strategies for resident #003, they stated the resident did not use safety equipment.

RN #101 told the LTCH Inspector they had re-instructed the PSW following the interview with the LTCH Inspector, that the resident did require the application of the safety equipment.

The licensee failed to ensure that care was provided to resident #003 as specified in their

plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented for residents #001 and #006.

a) On an identified date in February 2019, resident #001 had an unwitnessed fall while trying to self-transfer. Several days later the resident had a second unwitnessed fall.

Resident #001's plan of care directed staff to toilet the resident regularly.

RPN #102 told the LTCH Inspector that the PSWs toileted resident #001 frequently.

PSW #108 said they documented toileting of the residents in the resident's flow sheets.

The LTCH Inspector reviewed the documentation related to toileting for resident #001 and noted there was no documentation that the resident was toileted on the day of admission. Seven full days out of 26 days in the home, there was no documentation that the resident was taken to the toilet. On 14 full days, documentation occurred once. On two occasions there was documentation the resident was taken to the toilet twice in the full day.

PSW #107 told the LTCH Inspector that they were to document when they took a resident to the toilet on the toileting documentation form but she had not been doing so as she forgot about the form.

The Administrator/DOC told the LTCH Inspector the licensee did not have a policy related to the documentation form for toileting. Staff were aware they needed to document on the form when the resident had used the toilet.

The Administrator/DOC said the toileting documentation for resident #001 was incomplete based on the assessed needs as specified in the resident's plan of care.

b) Resident #006 had specialized equipment for comfort, safety and to offload pressure.

Resident #006's plan of care directed staff to turn and reposition the resident regularly when in bed and to turn them twice during the night.

The licensee's policy "Skin Care Management" with an effective date of March 2018,

directed staff to reposition residents at least every two hours while awake and document the position changes in flow sheets. While asleep, the resident was to be turned twice if clinically indicated,

A Turning/Change of Position Schedule form had been implemented for resident #006.

PSW #112 said the resident was on a turning program that consisted of repositioning them every two hours and documenting that on the turning form.

The LTCH Inspector reviewed the clinical record, specifically the "Turning/Change of Position Schedule" form for a period of time.

There was no documentation for the day shift. Evening shift documented infrequently, seven of the 11 dates. Seven evenings there was documentation of repositioning one time during the shift. On three occasions, the documentation was regarding the provision of specif care. On five of a total of 49 entries, staff noted which side the resident was turned on to. During the night shift, the frequency varied from two to four times per shift when staff repositioned the resident.

The RN acknowledged that staff had not complied with the documentation on the turning schedule form as required. [s. 6. (9) 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 The licensee must ensure that care set out in the plan of care is:
a) documented as specified in the plan and,
b) provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #5: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) was included in the plan of care for resident #003.

Resident #003 was observed by the LTCH Inspector using specialized equipment.

RN #104 told the LTCH Inspector that the specialized equipment was implemented for comfort and safety.

The LTCH Inspector reviewed the resident's plan of care that was in place and there were no entries related to the use of the specialized equipment as a PASD.

RN #110 told the LTCH Inspector that the PASD for resident #003 had not been included in their plan of care. [s. 33. (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 the licensee must ensure that the use of a Personal Assistance Services Device (PASD) is included in the resident's plan of care, to be implemented voluntarily.

WN #6: 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:
3. Continence care and bowel management. 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. 1) The licensee has failed to ensure that direct care staff received annual training related to continence care and bowel management.

The LTCH Inspector requested evidence of annual training of all direct care staff related to continence care and bowel management from the Administrator/DOC. They stated this had not been done as they were not aware it was required on an annual basis.

The licensee failed to ensure that all direct care staff received annual training in continence care and bowel management. [s. 221. (1) 3.]

2) The licensee failed to ensure that staff who provided direct care to residents were trained annually as per the LTCHA S.O. 2007, s. 76 (7), in the application, use and potential dangers of the PASDs.

The LTCH Inspector requested the training documentation related to all direct care staff being trained on the application, use and potential dangers of PASDs.

The Administrator said the home had not provided annual training related to PASD use for the years 2017, 2018 and 2019 to date. They were not aware this was an annual requirement.

The licensee failed to ensure that direct staff were provided training in the application, use and potential dangers of PASDs. [s. 221. (1) 6.] [s. 221. (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 the licensee must ensure that direct care staff receive annual training related to continence care and bowel management and the application, use and potential dangers of PASDs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to have his or her personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

As part of all residents' plans of care, the PSWs told the LTCH Inspector that there was a form posted beside every resident's bed that directed staff what care was required, their fall risk, fall prevention interventions and whether the resident had a specific medical condition as examples of information included on the form.

The LTCH Inspector reviewed the Resident Status Forms for resident #002 which was posted on the resident's bulletin board beside their bed in their room in plain view for anyone.

Resident #002's form included they had a specific medical condition.

RN #101 and the Administrator/DOC told the LTCH Inspector that they agreed the information posted on resident #002's Resident Status Forms at their bedside, was personal health information which had not been kept confidential.

The licensee failed to ensure that residents' personal health information was kept confidential. [s. 3. (1) 11. iv.]

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based and/or prevailing practices.

The LTCH Inspector reviewed the licensee's annual review of the Falls Prevention and Management Program for 2018.

The review included the Administrator/DOC, the Dietary Manager (DM), the Environmental Services Manager (ESM), the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator and the Director of Resident Care, all listed by first name and written in the top corner of the "Fall Assessment and Prevention" policy.

The annual review was conducted on April 20, 2018 and was a review of the licensee's policies related to the Fall Prevention program for typographical errors, grammar,

formatting and spelling. There were no changes identified to the contents of the Fall Prevention and Management program and no review of the program relative to evidence-based or prevailing practices.

The licensee included the following fall prevention and management policies in their policy manual that directed staff on actions to implement related to fall management and prevention:
1) Fall Prevention and Management – effective April 2019,
2) Post Fall Protocol – effective May 2018,
3) Nursing Assessment of the Resident After an Accident or Incident– effective June 2, 1988,
4) Guidelines for Completing Incident Form – effective date June 2, 1988,
5) Resident Incident Form – June 2017,
6) Post Fall Screen form – effective date May 2018,
7) Routine Head Injury Care – effective date August 25, 1988,
8) Resident Head Injury Report Form – October 2, 2000 and,
9) Fall Incident Assessment form – effective date May 2018.

The licensee's policy "Fall Prevention and Management" with an effective date of April 2019, directed staff to complete a Resident Incident Form and the Post Fall Screening form related to environmental factors. The tools were not clinically appropriate for the assessment of falls based on evidence-based and prevailing practice. The Resident Incident Form was a generic form to document any type of incident or accident.

The Administrator/DOC told the LTCH Inspector that the Resident Incident Forms were not clinically appropriate for the assessment of falls and was not based on evidence-based and/or prevailing practice. The incident form was a generic form to document any type of incident or accident. They were not able to provide evidence of the best-practice for post fall assessments.

The Administrator/DOC told the LTCH Inspector that the review did not include a review of the Fall Prevention and Management program related to evidence-based or prevailing practices. [s. 30. (1) 3.]

2. The licensee failed to ensure there was a written record relating to the annual evaluation of the continence care and bowel management program that included a summary of the changes made to the program and the date that those changes were implemented.

The LTCH Inspector reviewed the licensee's continence care and bowel management program review. The document provided by the Administrator/DOC was a form entitled "General Requirements for Programs" and was dated October 22, 2018.

The attendees were listed by first name and included the Administrator/DOC and the RAI/MDS Coordinator.

The notes in the section entitled "Summary of Changes Made" related to editing of the policy for font, format and other grammatical changes. There were notations that an unknown document was reviewed and that it was a good document. The document stated flow sheet audits were effective.

There was no clear review of the program, no summary of any changes that were identified for the program and no dates the changes were implemented.

The Administrator/DOC acknowledged the program review was not completed as required. [s. 30. (1) 4.]

Issued on this 25th day of July, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2019_787640_0020
Log No. / No de registre :	004561-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 24, 2019
Licensee / Titulaire de permis :	Clurelea Ltd. c/o Good Samaritan Nursing Home, 481 Victoria Street East, Alliston, ON, L9R-1J8
LTC Home / Foyer de SLD :	Good Samaritan Nursing Home 481 Victoria Street East, Alliston, ON, L9R-1J8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deirdre Britton

To Clurelea Ltd., 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 :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 49 (2).

Specifically, the licensee must:

1) Develop and implement a post fall assessment instrument that is clinically appropriate and specifically designed for falls, that is based on current evidence and/or prevailing practices and,
2) Provide all registered staff training in the implementation and use of the assessment instrument and keep a record of that training.

Grounds / Motifs :

1. The licensee failed to ensure that residents #001, #002, #003 and #004 had a post fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) On an identified date in February 2019, resident #001 had an unwitnessed fall. On a second date in February 2019, the resident had another unwitnessed fall. Two days following this fall, the resident's condition declined.

Following both falls, nursing staff completed a "Resident Incident Report" that included a section for the description of the incident, assessment findings and notification of the physician.

The licensee's policy "Fall Prevention and Management" with an effective date of April 2019, directed staff to complete a resident incident form and the post fall

screening form related to environmental factors. For those residents with three or more falls in a one-month period, a "Fall Incident Assessment" form was to be completed to guide future fall prevention, following which staff were to conduct an interdisciplinary conference to discuss the falls.

The home's policy "Guidelines for Completing Incident Forms" with an effective date of June 2, 1988, directed staff to:

- note description of resident including ambulation and normal habits,
- note the sequence of events including where and how the incident happened, was it witnessed and resident's perception,
- note staff action and preventive measures such as assessment protocol followed, treatment given and preventive measures and,
- note staffing conditions - number of nursing staff and deployment at the time of the incident (eg. bath or meal time)

RPN #102 told the Long-Term Care Homes (LTCH) Inspector when a resident had fallen, staff completed the “Resident Incident Report” and the “Post Fall Screening Assessment/checklist which included environmental/resident issues related to room clutter, lighting and footwear. The RPN said when a resident had three or more falls in a month, then a more complex form, “Post Fall Incident Assessment” was to be completed.

b) On an identified date in April 2019, resident #002 had an unwitnessed fall. Nursing staff completed a “Resident Incident Report” that included a section for the description of the incident, assessment findings and notification of the physician and the “Post Fall Screeniing” tool.

c) On an identified date in April 2019, resident #003 had an unwitnessed fall. Nursing staff completed a “Resident Incident Report” that included a section for the description of the incident, assessment findings and notification of the physician and the “Post Fall Screen” tool.

d) The Resident Incident Forms indicated that resident #004 fell on two identified dates in April 2019, with no signs of injury for either fall.

The Administrator/DOC told the LTCH Inspector that the resident incident forms

were not clinically appropriate for the assessment of falls and was not based on evidence-based and prevailing practice. The incident form was a generic form to document any type of incident or accident. They were not able to provide evidence of the best-practice for post fall assessments.

The licensee failed to ensure that resident's who had fallen were assessed using a clinically appropriate assessment instrument specifically designed for the assessment of falls.

The severity of this issue was determined to be level three, actual risk. The scope of the issue was determined to be level three, widespread, as four of four residents reviewed were involved. The compliance history was determined to be level two, with one or more previous non-compliance to a different section of the LTCHA. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 50 (2).

Specifically, the licensee must ensure that:

1) Residents #003 and #005 are repositioned every two hours or more often if clinically indicated, and that intervention is documented,
2) An audit of all residents is conducted to determine which residents are dependent on staff for repositioning,
3) A turning/repositioning program is implemented to include regular documentation of the intervention for all identified residents,
3) The specific turning/repositioning program is included in the resident's plan of care/kardex and PSWs documentation tools and,
4) All direct care staff are provided training on turning and repositioning of residents to include the requirements of the program and the documentation of the interventions and a record is kept of that training.

Grounds / Motifs :

1. The licensee failed to ensure that residents #003 and #005 who were dependent on staff for repositioning, were repositioned every two hours or more frequently as required.

a) Resident #003 had specialized equipment implemented as a personal assistance services device (PASD) for comfort and safety.

The plan of care directed staff to change the resident's position frequently, regularly and as per the turning program.

RN #104 told the LTCH Inspector that the specialized equipment was implemented for comfort and safety. They were not able to get themselves out of the specialized equipment without assistance of staff. Resident #003 was on the turning program.

Personal Support Worker (PSW) #105 told the LTCH Inspector that any resident using the specialized equipment only needed to be repositioned if they had any skin issues. At that time, they would be repositioned every two hours and documented on the "turning form".

The LTCH Inspector reviewed the clinical record, specifically the "Turning/Change of Position Schedule" form for the month of June 2019.

Ten of the 70 entries, included a check mark for the side the resident was placed on or that they were put to bed. The remaining days were a variety of documentation not all related to repositioning of the resident.

RN #104 said that staff were required to turn or reposition resident #003 every 2 hours and document the intervention on the turning schedule form.

b) Resident #005 had specialized equipment implemented for comfort, safety and to offload pressure.

Resident #005's plan of care directed staff to assist the resident with turning while in bed and implement the turning program.

RN #104 and RPN #102 told the LTCH Inspector that the specialized equipment was implemented for comfort and safety. Resident #005 was on the turning program and that staff were required to turn or reposition the resident every two hours and document the intervention on the turning schedule form.

PSW #111 told the LTCH Inspector that resident #005 only required turning and repositioning during the night. The resident used the specialized equipment all day so staff did not have to do the turning and repositioning.

The LTCH Inspector reviewed the clinical record, specifically the "Turning/Change of Position Schedule" form for a period of time in June 2019.

The documented dates contained notes that the resident had been repositioned. All times documented were for the night shift only. There was no pattern to the timing of the repositioning that occurred from every two- and one-half hours to three hours and on six of the eight dates, the resident was repositioned twice during the eight-hour night shift.

RN #104 acknowledged that staff had not complied with the turning program as the documentation on the turning schedule form had demonstrated, for residents #003 and #005. They said that staff were required to turn and reposition

residents #003 and #005 every two hours and based on what the PSWs had told the LTCH Inspector, they had not been implementing the turning program as required.

The severity of this issue was determined to be level two, minimal risk/minimal harm. The scope of this issue was determined to be level two as two of three residents reviewed were affected. The compliance history was determined to be level two as there was one or more previous non-compliance in other sections of the LTCHA. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must comply with O. Reg. 79?10, s. 51 (2).

Specifically, the licensee must ensure that:

1) Residents #003, #004 and #005 and any other resident who is incontinent, have an
individualized toileting plan based on an assessment to determine their individual toileting needs and,
2) All direct care staff receive training related to the assessment for, and development of, an individualized toileting plan for residents who are incontinent.

Grounds / Motifs :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

a) Resident #003 was assessed to be incontinent of bowel and bladder.

The toileting documentation sheet that was supposed to be used when staff took the resident to the toilet, was blank.

RN #104 told the LTCH Inspector the home did not do a specific observation period of residents to determine their toileting patterns and there were no individualized toileting plans developed for any resident.

RN #106 and PSWs #107 and #108 said they did not have any individualized toileting plans for any resident. They used their "change list" and went room by room.

b) Resident #004 was assessed to be continent of bowel and incontinent of bladder.

The resident's plan of care directed staff to toilet them regularly.

The clinical record was reviewed and the PSW documentation record/flow sheet for a period of 26 days. The documentation on the flow sheets identified the

resident was infrequently taken to the toilet.

c) Resident #005 was assessed to be continent of bowel and incontinent of bladder.

The resident's plan of care directed staff to toilet the resident regularly.

The LTCH Inspector reviewed the "Toileting Documentation" form for an 11 day period which identified infrequent toileting.

All documented dates contained documentation that the resident had been repositioned. All times documented were for the night shift only. There was no pattern.

The licensee failed to ensure that residents who were incontinent had an individualized plan to manage their bladder and bowel continence.

The severity of this issue was determined to be level two, minimal harm or minimal risk. The scope was determined to be level three, widespread with three of three residents reviewed involved. The compliance history was determined to be level two with one or more previous non-compliance in a different section of the LTCHA.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

Service Area Office /
Bureau régional de services : Central West Service Area Office