Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 2, 2018	2017_573581_0024	026622-17	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH HAMILTON ON L8N 2Z1

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

DIANNE BARSEVICH (581), JESSICA PALADINO (586), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 28, 29, 30, December 1 and 4, 2017.

During the course of this inspection, the following additional inspections were conducted concurrently:
Critical Incident System
021823-17- related to falls prevention
008291-17- related to falls prevention

Complaints
008066-17 - related to personal care

Follow Up
007418-17 - related to administration of drugs.

Inquires
006386-17- related to prevention of abuse

During the course of the inspection, the inspector(s) spoke with General Manager/DOC #001, Registered Nurse (RN), Registered Practical Nurse (RPN), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Recreation Supervisor, Personal Support Worker (PSW), Food Service Supervisor (FSS), families and residents.

During the course of the inspection, the inspectors observed the provision of care and services, toured the home, reviewed relevant policies and procedures, meeting minutes and clinical health records.

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
Nutrition and Hydration
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.
- **8 WN(s)**
- **5 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
O.Reg 79/10 s. 131. (1)	CO #001	2017_577611_0003	168

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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. Resident #014's documented plan of care under bed mobility identified they required bed rails for turning and repositioning; however, under the Personal Assistance Service Devices (PASD) section, indicated they required one bed rail. The resident's most recent Minimum Data Set (MDS) assessment from September 2017, indicated they used bed rails daily. In an interview with the RN #104 on an identified day in November 2017, confirmed that the plan of care did not provide clear direction for staff on the number of bed rails the resident required.

B. Review of the plan of care identified that resident # 011 wore continence products,

one specific size on all three shifts. Review of the Resident Profile Worksheet, dated November 2017, identified they wore a specific size on day and night shift and wore a different size product on evening shift. Interview with PSW #101 stated that the resident wore the same size product on days and evening shifts and a different size product on night shift. Interview with RPN #100 stated the resident required a different size product on night shift due to increased incontinence and confirmed that there was no clear direction to staff as to what type of product was worn on each shift. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The current plan of care for resident #012 identified a focus statement related to impaired visual status which noted that they had impaired vision, wore glasses and provided direction for staff to ensure the glasses were clean and being worn. A focus statement related to an identified responsive behaviour noted in an intervention that the resident had a specific visual impairment. A review of the most recent, September 2017, MDS assessment identified that the resident did not have a specific visual impairment and that the resident did not have any visual appliances, including glasses. Interview with the resident identified that they had glasses and had a specific visual impairment. Interview with PSW #101 and #105 verified the use of eye glasses. Following a review of the plan of care and assessment, interview with RPN #100 verified that the plan of care was reflective of the needs of the resident; however, not based on the assessment of the resident. [s. 6. (2)]

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

A. Review of the MDS assessment in March, June and September 2017, identified that resident #011 was frequently incontinent of bladder; however, their change in urinary continence was coded as deteriorated on the September assessment. The RAP in September, 2017, identified that the resident's clinical assessment had not changed since the last assessment. Interview with RPN #103 stated the resident's urinary continence had not deteriorated between assessments and confirmed that the MDS assessments and the RAP were not integrated and consistent with each other.

B. Review of the MDS assessment in June 2017, identified that resident #014 exhibited two specific responsive behaviours. The September 2017, MDS assessment identified

that the resident no longer exhibited one of the responsive behaviours and the other responsive behaviour had decreased in occurance; however, the change in behavioural symptoms was coded as no change. The RAP in September 2017, identified that the resident's clinical assessment had not changed since the last assessment. Interview with the GM/DOC #109 stated the resident's behavioural symptoms had improved between assessments and confirmed that the MDS assessments and the RAP assessments were not integrated and consistent with each other. (586)

C. Resident #012 had a MDS assessment completed in September 2017, which identified that they were occasionally incontinent of bowel function and frequently incontinent of bladder function. The Continence Assessment completed the same day in September 2017, identified that the resident was occasionally incontinent of bladder function and frequently incontinent of bowel function. Interview with RPN #100, who completed the Continence Assessment, confirmed that the two assessments were not consistent with each other, following a review of the records. (168)

D. Resident #012 had a MDS assessment completed in March 2017, which identified that they displayed an identified behavioural symptoms daily during the past seven days. A review of the MDS assessment completed in June 2017, identified that the resident displayed no behavioural symptoms in the past seven days and that there was no change in the behavioural symptoms, that the resident's behavioural status had not changed as compared to status of 90 days ago. Interview with RAI Coordinator, following a review of the two assessments verified that they were not consistent with each other. (168)

E. A review of the MDS assessment dated August 2017, identified that during the quarter, resident #015 had a specific infection. A review of the progress notes identified that the resident experienced symptoms during the identified time period, the physician was contacted and a diagnostic test was ordered to rule out an infection. The test was completed, the following day and identified that the resident did not have the specific infection and no medications were prescribed. The MDS assessment was not consistent with the diagnostic test, nor the actions from the physician. Following a review of the clinical record, the RAI Coordinator verified that the assessments were not consistent and did not complement each other. (168)

F. Resident #017 was identified with altered skin integrity during staff interview and a review of the clinical record. A review of the MDS assessments identified that they were not integrated or consistent with each other.

The February 2017, assessment identified the presence of one altered skin area and a history of unresolved skin areas.
The May 2017, assessment identified the presence of one altered skin condition; however, did not identify the type and noted that there was not a history of unresolved skin conditions.
The August 2017, assessment identified the presence of altered skin area which had deteriorated. A review of the Resident Assessment Protocol (RAP) for this assessment noted that the area was responding to interventions as outlined in the plan of care and that their clinical assessment had not changed from the last assessment.
The November 2017, assessment identified the presence of one altered skin condition which had significantly deteriorated. A review of the RAP for this assessment noted that the area was responding to interventions as outlined in the plan of care and that their clinical assessment had not changed from the last assessment.

Interview with RAI Coordinator following a review of the clinical record, verified that the MDS assessments and RAPs related to the residents skin conditions were not integrated nor consistent with each other. (168) [s. 6. (4) (a)]

4. The licensee failed to ensure that the care was provided to the resident as specified in the plan.

Resident #013's documented plan of care indicated that when the resident was in bed, staff were to leave one assist rail raised. A Bed Rail and Entrapment Risk Assessment was completed in September 2017, indicating the use of one bed rail. On three identified days in November 2017, the resident was observed in bed with two bed rails raised. Interview with PSW #103 on an identified day in November 2017, stated the resident required two rails while in bed. In an interview with RN #104 confirmed that care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #014's documented plan of care included the use of bed rails while in bed. The resident's bed system was observed with two bed rails raised. In an interview with the resident on an identified day in November 2017, the resident confirmed the use of the bed rails. The Bed Rail and Entrapment Risk Assessment forms were completed for the resident on an identified day in August 2017 and two identified days in September 2017; none of which included the outcome of the assessment or the interventions in place. In an interview with RN #104 on an identified day in November 2017, they confirmed that the resident used bed rails and acknowledged that the assessments completed did not include the use of the rails that the resident currently used.

Resident #014 was not assessed for the use of the bed rails. [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 where bed rails are used, 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 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 the plan of care for resident #012 identified that the resident had responsive behaviours. A focus statement related to toileting noted that the resident was to be toileted at specific times and as needed. The plan of care included a focus statement related to oral status which noted that the resident was to be assisted with oral care twice a day. Interview with RPN #100, PSW #101 and PSW #105 each identified that the staff attempted to provide the care as per the plan of care; however, that the resident consistently, on a daily basis refused toileting and oral care.
A review of the Point of Care (POC) records, for the past 30 days, related to a specific responsive behaviour identified that the behaviour was not exhibited in the past 30 days.
A review of the POC records, for the past 30 days, related to oral care, identified that the resident refused the care on several occassions.
A review of the POC records, for the past 30 days, related to how the resident used to toilet, identified that the resident refused the provision of care on numerous occasions; however, consistently included the level of assistance provided.
Interview with RPN #100 verified that the resident was consistently resistive to care; however this response to care was not documented as required. [s. 30. (2)]

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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 the resident who exhibited 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.

On an identified day in April 2017, resident #040 fell and sustained two injuries, was sent to hospital and returned with a specific device. Review of the clinical record did not include a Skin- Head to Toe Skin Assessment when they returned from hospital on an identified day in April 2017. Interview with the GM/DOC #109 stated that a referral was sent to the wound care champion; however, confirmed the skin assessment using a clinically appropriate instrument was not completed. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration were implemented.

The plan of care identified that resident #017 had an area of altered skin integrity since June 2017. A review of the clinical record included an Initial New Wound Assessment. This assessment identified that a referral was made to the Registered Dietitian (RD)

related to the presence of the area. A review of the clinical record did not include an assessment, by the RD, of the resident related, to the presence of the altered skin integrity and resident was not assessed, until a quarterly review completed several weeks later, which included the altered skin integrity.

Interview with the RD on December 1, 2017, confirmed awareness of the area; however, they did not have recall if a referral was received or not, or of actions taken. At the time of the interview they did not have access to the clinical record. Interview with the Food Service Supervisor (FSS) and RAI Coordinator on an identified day in December 2017, identified that there was no referral to the RD when the area of altered skin integrity was identified in June 2017 and that the RD did not complete an assessment related to the change in care needs. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that the resident who exhibited 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. Resident #017's plan of care was reviewed and identified that the resident had an area of altered skin integrity which was assessed and documented in the clinical record, under the assessment tab of Point Click Care (PCC). A review of the clinical record did not consistently include an assessment of the area by a member of the registered nursing staff specifically:
i. between an identified day in August and twelve days later in August 2017,
ii. between an identified day in August and thirteen days later on an identified day in September 2017,
iii. between an identified day in September and fifteen days later on another identified day in September 2017, and
iv. between and identified day in November and twenty two days later on an another identified day in November 2017.

Interview with the RAI Coordinator #112, following a review of the record, confirmed that a weekly reassessment of the area, by a member of the registered nurse staff, was not completed as required.

B. Resident #040 was identified with altered skin integrity post fall on an identified day in April 2017. A review of the clinical record did not include a reassessment of the altered skin integrity on a weekly basis. Interview with GM/DOC #109, following a review of the clinical record, confirmed that the identified area was not assessed weekly as required.

(581) [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 the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home and any changes made to the plan of care related to nutrition and hydration are implemented; to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service

provider.

On request the home provided a copy of their medication incident and adverse drug reactions for the past six months.
A review of three of these incidents identified that not all residents were consistently assessed following the incident nor were all of the required parties reported to, with regards to the incident.
i. Resident #017 was involved in a medication incident in June 2017, which was identified and reported the following day. A review of the medication incident reports available and the clinical record did not include immediate actions taken to assess and maintain the resident's health and that the resident's SDM nor the physician were notified of the incident. Following a review of the available documentation the GM/DOC #109 identified that to their recall the substitute decision maker (SDM) was notified of the incident; however, that there was no documentation to support that action and that there was no record of an assessment nor physician notification.
ii. Resident #015 was involved in a medication incident in October 2017, which was identified and reported the same day. A review of the medication incident reports available and the clinical record did not include that the resident's SDM was notified of the incident. Following a review of the available documentation the GM/DOC #109 identified that their was no documentation to support that the SDM was notified of the incident. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

On request the home provided a copy of their medication incident and adverse drug reactions for the past six months. A review of three of these incidents identified that documentation did not support that all incidents were analyzed nor that corrective action was taken as necessary.
i. Resident #017 was involved in a medication incident in June 2017, which was identified and reported the following day. A review of the medication incident reports available and the clinical record did not include that the incident was analyzed or that corrective action was taken as necessary. Following a review of the available records the GM/DOC #109 identified that actions were taken in relation to this incident; however, was not able to provide documentation to the actions taken.
ii. Resident #015 was involved in a medication incident in October 2017, which was identified and reported the same day. A review of the medication incident reports

available and the clinical record did not include that the incident was analyzed or that corrective action was taken as necessary. Following a review of the available records the GM/DOC #109 identified that actions were taken in relation to this incident, including discussing the incident with concern with corporate staff; however, was not able to provide documentation to the actions taken. [s. 135. (2)]

3. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, that any changes and improvements identified in the review were implemented, and a written record was kept of everything provided for.

On request the home provided a copy of the medication incident and adverse drug reaction reports for the past six months. Interview with the GM/DOC #109 identified that a quarterly review of all incidents was completed at the Professional Advisory Committee (PAC). The most recent PAC meeting minutes, dated on an identified day in October 2017, were provided with, an attached, Clinical Consultant Pharmacist Quarterly Report. A review of the minutes and report noted that medication incidents were discussed related to the number, classification of the incidents and a very brief statement about what the error was. Interview with the GM/DOC #109, following a review of the minutes and report, confirmed that the documents were not supportive of the entire discussion at the meeting and that a comprehensive record was not maintained of the review as required. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident which involved a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required, to be implemented voluntarily.

WN #6: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, section 68 requires, "a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter".

The home's policy, "Weight & Height Monitoring" (policy tab 04-76), indicated that heights would be measured annually and entered into the village software.

During the inspection it was identified that not all residents had their heights taken and recorded annually. Records identified that five residents reviewed did not have their height completed on an annual basis; last recorded in February 2016, over 21 months ago. In an interview with the RD on an identified day in November 2017, they acknowledged and confirmed that resident heights were taken on admission and annually thereafter; however, there was an oversight for those residents that have not had them completed since 2016. Staff did not comply with the home's policy as directed. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the residents vision.

Resident #014 was observed on three identified days in November 2017, wearing glasses. In an interview with PSW #103, they confirmed that the resident wore glasses daily. Review of the resident's MDS assessments in August 2017 and from a significant change in status in September 2017, indicated that the resident did not use any visual appliances, including glasses and also indicated that the resident had impaired vision. The resident's documented plan of care did not include a section around vision, nor did it include the resident's daily use of glasses. [s. 26. (3) 4.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that they sought the advice of the Residents' Council in the development and carrying out of the satisfaction survey, and in acting on its results.

A review of the Residents' Council Meeting Minutes for 2017, identified that the home was in the process of completing their 2017, Resident Satisfaction Survey. A review of the meeting minutes did not include that the council was asked for advice on the development and the carrying out of the survey. Interview with the Residents' Council assistant verified during an interview that a new survey was implemented with a change in ownership, that staff, at that time, reviewed and provided feedback on the survey; however, that the advice of the council was not sought. [s. 85. (3)]

Issued on this 18th day of January, 2018

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

Original report signed by the inspector.