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
Dec 7, 2017	2017_661683_0010	019142-17	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the City of Brantford and the Corporation of the County of Brant
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET BRANTFORD ON N3T 1T5

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

LISA BOS (683), ALISON FALKINGHAM (518), DIANNE BARSEVICH (581), LISA VINK (168), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 26, 27, 2017.

The following intakes were completed concurrently with this inspection:
031782-16 - Prevention of Abuse and Neglect
011093-17 - Prevention of Abuse and Neglect
003256-17 - Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Coordinator (RCC), Environmental Services Manager (ESM), Registered Dietitian (RD), Coordinator of Recreation Program and Volunteer Services, Registered staff, Personal Support Workers (PSW), dietary aides, Physiotherapy Assistants (PTA), residents and families.

During the course of the inspection the inspectors toured the home, reviewed resident clinical records, policies and procedures, the home's complaints binder, video footage and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On an identified date, Inspectors #518 and #168 observed the Therapy room had the entrance doors open, no staff were in attendance and the area was accessible to residents. The room included a Hydrocollator Heating Unit, with hot packs immersed and steaming water visible and under the sink, in an unsecured cabinet, a container of WD40 with a label which included "harmful if swallowed" and a spray can of Stainless Steel Cleaner, with a label which identified the product was toxic.

On an identified date, Physiotherapy Assistant (PTA) #134 entered the Therapy room prior to the Inspectors leaving the area. The staff member identified that the doors to the room were to be locked and the room secured at all times unless staff were in attendance or while staff were portering residents to and from their home areas. It was confirmed by the PTA that the room contained hazards, specifically the heating unit for moist heat packs and the chemicals, and on reconsideration identified that the room should be kept locked at all times when staff were not in attendance.

The home was not a safe and secure environment for its residents. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #001 sustained a fall on an identified date. The Post Falls Note identified that although the fall was not witnessed, the resident was probably trying to self-transfer.

Resident #001 was identified at risk of falls, based on the Falls Risk Assessment Tool.

On an identified date, the resident's plan of care was reviewed and included the focus

statement which identified a potential for injury related to a specific disease process, along with a goal for the resident to have a reduced number of falls and interventions, and identified specific interventions for falls prevention. The resident had a plan of care related to toileting and continence of bowel and bladder which identified that the resident was dependent on staff for the level of assistance required to complete the task and continence status; however, not the frequency of the activity.

On an identified date, PSW #119 was interviewed and identified that the resident was at risk of falls. Interventions identified by the PSW to manage this risk included positioning of the bed and call bell in addition to toileting the resident to prevent self-transfers. It was identified that the resident was not on a toileting plan.

On an identified date, PSW #135 indicated that the resident would try to get themselves up when they had to go to the bathroom and had a history of attempting to transfer themselves.

On an identified date, RPN #151 was interviewed regarding the resident and following an initial review of the plan of care could not identify if the resident was at risk of falls; however, after consultation with RPN #152 identified that based on the Fall Risk Assessment Tool from an identified date, they were at risk. It was identified that there were interventions in place to prevent falls. RPN #151 identified that the resident was not on a toileting routine; however, was incontinent.

On an identified date, RPN #136 identified that the resident was toileted by staff, was not on a toileting routine nor was the frequency of toileting identified; however, they did not think that the resident would attempt to self-transfer.

On an identified date the Resident Care Coordinator (RCC) reviewed the resident's plan of care and portions of the clinical record. They verified that the focus statement ideally would have included the statement "falls," for clarity; although, noted that this information was included in the goal for the resident. They further identified that the plan did not give clear direction to staff related to the risk of self-transfers and the routine to toilet the resident.

The plan of care did not give clear direction to staff providing care. [s. 6. (1) (c)]

2. 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) The record of resident #006 was reviewed. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) from an identified date, indicated that the resident had an identified diagnosis. The resident's care plan was reviewed and it did not include a focus, goals or interventions related to the identified diagnosis. There was no documentation found in the resident's record of any other assessment or interventions related to the identified diagnosis. The resident was interviewed and denied having the identified diagnosis.

The RCC was interviewed and they reported that they reviewed the resident's record and found no documentation of the resident having the identified diagnosis. They indicated that the diagnosis included in the RAI-MDS assessment must have been a coding error. They confirmed that the staff and others involved in the different aspects of care of resident #006 did not collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

B) Review of the Nutrition and Hydration Risk Identification Tool completed on an identified date for resident #044 did not identify under high nutrition risk indicators that the resident had an area of altered skin integrity. Review of the skin assessment completed in the progress notes on four identified dates around the time the identified Nutrition and Hydration Risk Identification Tool was completed, identified the resident had an area of altered skin integrity on an identified body part. Interview with the Registered Dietitian (RD) identified that the resident had an area of altered skin integrity and confirmed that the two assessments were not integrated and consistent with each other.

C) On an identified date in 2017, the skin assessment identified that resident #048 had an area of altered skin integrity. Four days later, the skin assessment was completed and indicated that the identified alteration to the resident's skin integrity had declined to an identified level. Review of the Treatment Administration Record (TAR) 21 days later, revealed that they had an area of altered skin integrity consistent with the first assessment identified above. Interview with RPN #130 stated the identified area of altered skin integrity further declined and confirmed that the skin assessment and the TAR were not integrated and consistent with each other.

D) Review of the plan of care for resident #004 indicated they fell on three occasions

within 52 days. Review of the MDS assessment on an identified date in 2017, indicated they fell in the past 30 days; however did not identify they fell in the past 31 to 180 days. Interview with RPN #103 stated the resident had three falls and confirmed that the resident had a fall in the past 31 to 180 days and the MDS assessment and the Post Fall Note Assessments were not integrated and consistent with each other.

E) Review of the plan of care for resident #007 indicated they fell on two occasions within 70 days. Review of the MDS assessment on an identified date in 2017, indicated they fell in the past 30 days; however did not identify they fell in the past 31 to 180 days. Interview with RAI Coordinator #153 and review of the post falls note confirmed that the resident fell in the past 31 to 180 days and the MDS assessment and the Post Fall Note assessments were not integrated and consistent with each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complimented each other.

Review of the Minimum Data Set (MDS) assessment on one identified date in 2017, identified that resident #004 was occasionally incontinent of bladder and the subsequent MDS assessment indicated they were frequently incontinent of bladder; however, their change in urinary continence was coded as no change. Interview with RPN #103 stated the resident's urinary continence had deteriorated between MDS assessments and confirmed that the subsequent MDS assessment failed to reflect the care being documented in Point of Care (POC). [s. 6. (4) (b)]

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

A) Review of the plan of care for resident #044 identified they had skin breakdown. Review of the TAR for an identified month in 2017, indicated they had an identified area of skin breakdown and had a specific treatment that was to be completed at specific times each day until clear. Interview with RPN #103 and review of the TAR stated that they did not know that the treatment was to be applied at one of the specific times each day and confirmed that the resident did not receive the care as specified in the plan at the identified time for an identified time period in 2017.

B) The plan of care for resident #044 identified that a treatment for an area of altered

skin integrity was discontinued on an identified date in 2017. Interview with PSW #140 stated on an identified date following discontinuation of the product, when providing care, they applied the identified treatment to the area of altered skin integrity and that they had received the treatment from the registered staff. Interview and review of the TAR with RPN #142, stated they gave the treatment to PSW #140 to apply to the resident's area of altered skin integrity, confirmed the treatment was discontinued and that the resident received a treatment that was not specified in the planned care.

C) Review of the clinical record for resident #007 identified that they were to have four specific adaptive devices in place at meals.

Lunch was observed on an identified date in 2017. The resident was observed to have three of their adaptive devices in place, but was not provided with one of their adaptive devices.

Interview with dietary aide #149, following the lunch meal, identified that they were not aware that the resident required any adaptive aids at meals. After review of the Meal Service Notes, they acknowledged that the resident required a specific adaptive device at meals. They identified the adaptive device within the servery and identified that it was the device that the resident should have had at their meal. Dietary aide #149 confirmed that the resident did not receive the adaptive device as per their Meal Service Notes at lunch on an identified date in 2017.

Interview with the Nutrition Services Supervisor, on an identified date, verbalized that it was the expectation that staff were to refer to the meal service notes at all times. They identified that the Meal Service Notes were included as part of the plan of care for residents and were updated regularly. They identified that the resident was to use a specific adaptive device at meals, due to an identified diagnosis.

The licensee did not ensure that resident #007 was provided their adaptive device at lunch on an identified date in 2017, as specified in their plan of care. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #040's written plan of care indicated they required extensive assistance for transferring with two staff with the mechanical lift and they were able to transfer from their ambulation equipment to the bed with the assistance of two staff. Interview with the

resident stated they were transferred in and out of bed and on and off the toilet with the mechanical lift and they were no longer able to transfer back to bed with a two staff assisted pivot transfer. Interview with PSW #104 stated the resident was transferred with the mechanical lift for an identified number of months for all transfers. Interview and record review with RPN #103 stated the resident was only transferred with the mechanical lift with two staff assistance and confirmed the plan of care was not reviewed and revised when the resident's care needs changed.

B) Review of the plan of care for resident #044 indicated they had two specific medical interventions in place for skin integrity. Review of the TAR indicated that one of the interventions was discontinued on an identified date, and the other intervention was discontinued the next day. Interview with RPN #133 stated that the resident was to have a new intervention completed twice a day and that the other two interventions had been discontinued. They confirmed that the plan of care was not reviewed and revised when the resident's care needs changed.

C) Review of the skin assessment on an identified date for resident #048 identified they had an area of altered skin integrity at an identified level and the written plan of care identified the area of altered skin integrity at a different level. Interview with RPN #130 stated that the resident had an area of altered skin integrity at an identified level, and confirmed the plan of care was not reviewed and revised when the resident's area of altered skin integrity deteriorated. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other, that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: 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 in compliance with and was implemented in accordance with all applicable requirements under the Act.

O. Reg. 79/10, s. 50 (2) (b) (iii) identifies that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by the 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.

The home's policy number 3-H-10, "Skin/Wound Care", dated December 2016, was reviewed and directed registered staff to "make referrals to interdisciplinary team members or outside resources as required (for example, the registered dietitian, physiotherapist/occupational therapist)."

Interview with RPN #103 and #130 stated that if a resident exhibited altered skin integrity, including skin breakdown and pressure ulcers they would refer to the RD if the wound was not healing, deteriorating, slow to heal and they were not eating well; however, would not refer to the RD if they had a skin tear or if the registered staff were managing the wound with the interventions that were in place. Interview with the DOC stated that all residents with altered skin integrity should have been assessed by the RD, confirmed that the home's skin and wound policy did not indicate that all resident's with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds would be assessed by the RD and that the home's policy did not meet all applicable

requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or the Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) Ontario Regulation 79/10, section 114, requires the home to have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home had a procedure, Insulin Administration – Using the Novolin Pen-3, #-D-440, which identified the procedure to administer insulin using the Novolin Pen. It directed staff to "prime the pen to remove air from the cartridge (air shot), turn the does dial to (2), hold the pen with the needle up, tap the plastic insulin cartridge holder to move any air bubbles to the top, push the injection button all the way in, listening for clicks and checking to observe a stream of insulin being expelled from the tip of the needle, if the insulin stream does not appear, repeat the procedure until priming is complete – then turn the dose dial to the dose that is required for administration."

On an identified date, during the noon medication pass, RPN #113 was observed to prepare an identified resident's medication which included insulin, via an insulin pen. The RPN failed to prime the insulin pen prior to dosage selection and the administration of the injection, as observed by the Inspector.

Interview with the DOC verbalized the expectation for the administration of insulin. When an insulin pen was used, the registered staff member was to prime the pen with two units of insulin prior to dosage selection.

Interview with RPN #113, on an identified date, confirmed that they received education, on an ongoing basis from the pharmacy, and was previously instructed in the use of the insulin pen, which required priming prior to each use.

B) The home's policy and procedure number 3-M-12, RAI MDS, revised August 2016, was reviewed and included: "RAI-MDS provides the interdisciplinary care team with a common assessment tool and care planning process. The assessment and outcomes will be used to improve quality of care for the residents through further assessments,

evaluation and updated care plans."

The record of resident #006 was reviewed including the RAI-MDS assessment for an identified date in 2017, and it indicated that the resident had an identified diagnosis. The care plan was reviewed and did not include any information related to the identified diagnosis. There was no documentation of the resident having the identified diagnosis found in the resident's record.

RAI-MDS Coordinator #101 was interviewed and confirmed that the home's policy and procedure was not followed as above.

C) The home's policy number 3-C-10 "Continence Care Program," last revised September 2016, directed registered nursing staff to collaborate with the resident, substitute decision maker (SDM) and interdisciplinary team to:

i. Conduct a bowel and bladder continence assessment on admission, quarterly and after any change in condition that may affect bladder or bowel continence.
ii. The assessment must include identification of casual factors, patterns, types of incontinence, potential to restore function and identify type and frequency of physical assistance necessary to facilitate toileting.

Review of resident #005's clinical record identified that they had an identified continence intervention. Review of the plan of care identified they had an MDS Bedside Assessment on an identified date in 2017, which included assessment of the resident's continence. There were no further MDS Bedside Assessments or Bowel and Bladder Continence Assessments identified in the clinical record.

On an identified date, RN #146 reviewed the resident's clinical record and was unable to identify a Bowel and Bladder Continence Assessment for resident #005.

On an identified date, the RCC acknowledged that the home did not follow their continence policy for approximately the past two months, due to staffing changes as well as changes in the assessments. Interview with the RCC acknowledged that the quarterly bladder and bowel continence assessments were not completed for resident #005, as per their policy, since an identified month in 2017.

The home did not ensure that their Continence Care Program was complied with.

D) The home's policy number 3-C-10 "Continence Care Program," last revised September 2016, directed registered nursing staff to collaborate with the resident, substitute decision maker (SDM) and interdisciplinary team to:

i. Conduct a bowel and bladder continence assessment on admission, quarterly and after any change in condition that may affect bladder or bowel continence.
ii. The assessment must include identification of casual factors, patterns, types of incontinence, potential to restore function and identify type and frequency of physical assistance necessary to facilitate toileting.

Review of resident #004's MDS assessment completed on an identified date in 2017, identified they were frequently incontinent of bladder, continent of bowels and required identified continence products. Review of the plan of care identified the quarterly Bladder and Bowel Continence Assessment was last completed on an identified date in 2017, and was not completed after that quarter according to the RAI-MDS schedule. Interview with RPN #103 stated that the home did not complete the quarterly Bladder and Bowel Continence Assessments in two identified months in 2017, and confirmed that an assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not completed quarterly as required by the home's policy.

E) The home's policy number 3-C-10 "Continence Care Program," last revised September 2016, directed registered nursing staff to collaborate with the resident, substitute decision maker (SDM) and interdisciplinary team to:

i. Conduct a bowel and bladder continence assessment on admission, quarterly and after any change in condition that may affect bladder or bowel continence.
ii. The assessment must include identification of casual factors, patterns, types of incontinence, potential to restore function and identify type and frequency of physical assistance necessary to facilitate toileting.

Review of the MDS assessment in an identified month in 2017, for resident #006 identified they were frequently incontinent of bladder, continent of bowels and was on an identified toileting schedule. Review of the plan or care revealed that the quarterly Bladder and Bowel Continence Assessment was last completed on an identified date in 2017. Interview and review of the clinical health record with RPN #130 stated that the assessments were not completed with the next two MDS quarterly assessments and confirmed that an assessment using a clinically appropriate instrument that was

specifically designed for assessment of incontinence was not completed quarterly as required by the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act and is complied with, 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by the registered dietitian who was a member of the staff of the home and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A) Review of the skin assessment on an identified date for resident #044 identified they had an area of altered skin integrity on an identified body part. Interview with the RD stated that they were aware of the area of altered skin integrity; however, confirmed they did not receive a referral from the registered staff at the time the area was identified and did not reassess the resident.

B) Resident #048's plan of care was reviewed and identified they had an area of altered skin integrity to an identified body part. Review of the skin assessments on an identified date, indicated there was a specific alteration in the skin integrity on the identified body part, four days later, revealed the identified alteration in skin integrity deteriorated to an identified level, and 16 days later, the identified alteration in skin integrity deteriorated further. Review of the progress notes identified the RD reassessed the resident on an identified date, and added more protein to their diet. Interview with RPN #130 revealed they sent a referral to the RD on an identified date; however, confirmed that the referral should have been sent when the area of altered skin integrity was at an identified level, which was earlier than the date they sent the referral. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by the 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) As per the home's policy number 2-A-50, "General Cleaning and Disinfecting of Equipment," last updated June 2016, "Basins, wash basins, foot basins, urinals, bedpans – Nursing staff to clean on each shift. Dedicated use of equipment, each resident to have their own to be cleaned/rinsed after use and disinfected."

Resident #005 had an identified continence intervention and staff utilized specified collection containers for the resident. On an identified date, the resident's shared bathroom included a specified collection container positioned on the back of the toilet which was unclean.

On an identified date, PSW #119 was observed to obtain a specified collection container from the resident's bathroom cabinet. The item was then used for care. Once care was completed, the PSW rinsed the container in the sink before they added hand soap and tap water to the container and quickly washed the container before towel drying it and storing it in the cabinet. PSW #119 acknowledged that there were two specified collection containers in the resident's bathroom drawer, one which was identified to be unclean, which was discarded by staff.

Interview with the DOC by inspector #518 on an identified date, acknowledged that the home's expectation was that staff were to clean personal care items if they were soiled and to disinfect the items with Virox.

The licensee did not ensure that resident #005's collection container was cleaned/rinsed after use and disinfected.

B) As per the home's policy number 3-B-60, "Resident Personal Belongings," last reviewed April 2015, "All resident's sharing a washroom will have their personal toiletries

labelled through the labelling process in the nursing department. On a continual basis staff monitor belongings in the washroom and label with personal printed labels as necessary."

On an identified date, a blue unlabelled urinal was observed on the back of the toilet in resident #005's shared washroom, and two unlabelled collection containers were noted in the drawer in the shared washroom. PSW #119 identified that resident #005 did not use the shared washroom, and that the blue urinal belonged to another resident. They confirmed that the blue urinal and the collection containers were not labelled.

Interview with the DOC by inspector #518 on an identified date, noted the home's expectation for resident's personal care equipment including wash basins and urinals in shared washrooms was that the items were to be labelled. They identified that labels were provided on each home area and that the ward clerk applied labels to the initial care basket and the rest of the items were to be labelled by PSW staff.

The licensee did not ensure that staff participated in the implementation of the infection prevention and control program for the labelling of personal care items in the shared bathroom of resident #005.

C) Interview with the DOC by Inspector #518 on an identified date, acknowledged that the home did not clean an identified piece of continence equipment, they discarded them after use when dirty. It was identified that the home had an ample supply of the identified continence equipment and that the clean equipment should be stored in an identified manor in the bathroom.

On an identified date, an identified piece of continence equipment which contained a small amount of a dried amber coloured liquid was observed in a drawer along with two collection containers in the shared washroom of resident #005. PSW #119 confirmed that resident #005 did not use the identified piece of continence equipment and that it should have been discarded.

The home did not ensure that staff participated in the implementation of the infection prevention and control program for removal and storage of resident #005's identified piece of continence equipment.

D) As per the home's policy number 3-B-60, last reviewed April 2015, "the John Noble Home will ensure that all resident personal belongings in shared washrooms are labeled

for identification"

On an identified date, the DOC, who was also the Infection Control Lead, communicated the home's expectation that all resident personal items were labelled and that labels were provided for each resident on admission.

During Stage 1 of the RQI, Inspector #518 observed that not all personal care items, in shared washrooms were labelled for identification as required.
a. On an identified date, resident #003, had two washbasins unlabelled and on the floor of their shared washroom, an unlabelled urinal on the back of the toilet tank, and an unlabelled container of mouthwash on the bathroom counter.
b. On an identified date, resident #007, had two unlabelled wash basins and an unlabelled bed pan on the floor of their shared washroom.
c. On an identified date, resident #053, had an unlabelled wash basin and an unlabelled raised toilet seat on the floor in their shared washroom.
On an identified date, Inspector #518 observed no changes to the bathrooms of residents #003, #007 or #053, all items were still noted to be unlabelled and stored on the floors or back of the toilet.

On an identified date, PSW #150 confirmed that unlabelled items, in shared washrooms, and items on the floor, was not consistent with the infection control expectations. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act, that the resident was released from the physical device and repositioned at least once every two hours.

Review of the clinical record for resident #005 identified that they required the use of of a physical device as a restraint for safety and a Personal Assistive Service Device (PASD) for positioning.

Resident #005 was observed on an identified date from 0830 hours to 1108 hours in an identified mobility device with a PASD and a restraint in place. At 1020 hours, the resident was repositioned by PSW #135; however, the restraint was not released. The resident's restraint was not released during the time of observation from 0830 hours to 1108 hours.

Interview with PSWs #144 and #143 identified that they provided care to the resident on the identified shift and released resident #005's restraint at 1030 hours and at around 0930 to 0945 hours, respectively, on an identified date.

Review of video footage for the identified time period, identified that the resident was brought outside the dining room at 0807 hours with their PASD and restraint in place. It included staff interactions with the resident until 1026 hours when the resident was portered to an activity program and then returned to the unit at 1106 hours. The video was reviewed from the time stamped period beginning at 0807 hours to 1108 hours and in that time, the resident was repositioned; however, the restraint was not released.

The licensee did not ensure that resident #005 was released from their restraint at least once every two hours. [s. 110. (2) 4.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and that all assessment, reassessment and monitoring, including the resident's response were documented.

A) Review of the clinical record for resident #031 identified that they required the use of a physical device as a restraint for safety.

Interview with RPN #136 identified that registered staff were to check residents with restraints every eight hours and were to document that the restraint was checked and the effect of the restraint in the progress notes.

Review of the progress notes for resident #031 identified restraint notes, which included headings for reason for use, effect, further use required and review of PSW documentation. Progress notes were reviewed between an identified time period in 2017, for resident #031 related to the reassessment of the use of the restraint. A review of the records identified that "effect" was documented as "yes," and "effective [Resident #031] remained safe this shift."

On an identified date, on request, the Director of Care (DOC) reviewed the restraint progress notes completed by the registered staff for resident #031. It was confirmed that staff did not document resident #031's response to their restraint as required or intended.

B) Review of the clinical record for resident #032 identified that they required the use of

a physical device as a restraint for safety.

Interview with RPN #136 identified that registered staff were to check residents with restraints every eight hours and were to document that the restraint was checked and the effect of the restraint in the progress notes.

Review of the progress notes for resident #032 identified restraint notes, which included headings for reason for use, effect, further use required and review of PSW documentation. Progress notes were reviewed between an identified time period in 2017, for resident #032 related to the reassessment of the use of the restraint. A review of these records identified that "effect" was documented as "yes," and "effective. [Resident #032] remained safe."

On an identified date, on request, the DOC reviewed the restraint progress notes completed by the registered staff for resident #032. It was confirmed that staff did not document resident #032's response to their restraint.

C) Review of the clinical record for resident #005 identified that they required the use of a physical device as a restraint for safety.

Interview with RPN #136 identified that registered staff were to check residents with restraints every eight hours and were to document that the restraint was checked and the effect of the restraint in the progress notes.

Review of the progress notes for resident #005 identified restraint notes, which included headings for reason for use, effect, further use required and review of PSW documentation. Progress notes were reviewed between an identified time period in 2017, for resident #005 related to the reassessment of the use of the restraint. A review of these records identified that "effect" was documented as "yes," "effective" or "with good effect" when the restraint was in use.

On an identified date, the DOC reviewed, on request, the restraint progress notes completed by the registered staff for resident #005. They identified that when staff documented the effect of the resident's restraint as "effective," that it appeared they were charting regarding the goal of the device, rather than how the resident responded to the restraint, which was the home's expectation. It was confirmed that staff did not document resident #005's response to their restraint. [s. 110. (7) 6.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and included every release of the device and all repositioning.

A) On an identified date, resident #031 was observed with a physical device applied. Review of the clinical record identified that they required the use of a physical device as a restraint for safety.

Review of POC documentation under "restraint in use" and specific task details for resident #031 identified that PSW staff were to document the provision of care related to restraints, under seven follow up questions which were as follows: checked, applied, repositioned, removed, resident not available, resident refused, not applicable. PSW staff were able to document who applied the device and the specific time that it was applied (to the nearest hour), with who removed the device and the specific time that it was removed.

On an identified date, during an interview with the DOC and RCC a review of the home's POC documentation of restraints for resident #031 was completed. It was identified and confirmed that the current documentation available in the home did not include every release of the device and all repositioning of residents who were restrained. The DOC and the RCC confirmed that every release of the restraint and repositioning for resident #031 were not documented.

B) On an identified date, resident #032 was observed with a physical device applied. Review of the clinical record for resident #032 identified that they required the use of a physical device as a restraint for safety.

Review of POC documentation under "restraint in use" and specific task details for resident #032 identified that PSW staff were to document the provision of care related to restraints, under seven follow up questions which were as follows: checked, applied, repositioned, removed, resident not available, resident refused, not applicable. PSW staff were able to document who applied the device and the specific time that it was applied (to the nearest hour), with who removed the device and the specific time that it was removed.

On an identified date, during an interview with the DOC and RCC a review of the home's POC documentation of restraints for resident #032 was completed. It was identified and confirmed that the current documentation available in the home did not include every

release of the device and all repositioning of residents who were restrained. The DOC and the RCC confirmed that every release of the restraint and repositioning for resident #032 were not documented.

C) On an identified date, resident #005 was observed with a physical device applied. Review of the clinical record for resident #005 identified that they required the use of a physical device as a restraint for safety.

Review of POC documentation under "restraint in use" and specific task details for resident #005 identified that PSW staff were to document the provision of care related to restraints, under seven follow up questions which were as follows: checked, applied, repositioned, removed, resident not available, resident refused, not applicable. PSW staff were able to document who applied the device and the specific time that it was applied (to the nearest hour), who with who removed the device and the specific time that it was removed.

On an identified date, during an interview with the DOC and RCC a review of the home's POC documentation of restraints for resident #005 was completed. It was identified and confirmed that the current documentation available in the home did not include every release of the device and all repositioning of residents who were restrained. The DOC and the RCC confirmed that every release of the restraint and repositioning for resident #005 were not documented. [s. 110. (7) 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 every use of a physical device to restrain a resident under section 31 of the Act is documented and that all assessment, reassessment and monitoring, including the resident's response are documented and that every release and all repositioning is documented, to be implemented voluntarily.

WN #7: 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) The plan of care for resident #044 identified a specific treatment for an area of altered skin integrity. Review of the TAR for an identified time period of approximately four months, indicated they were to have the treatment for the area of altered skin integrity applied at specific times each day; however, registered staff did not consistently document that the resident received the treatment according to their plan of care 23 times during the identified time period.

Review of the TAR for a period of approximately 5 months, for resident #044 identified they were to receive another specific treatment for an area of altered skin integrity, which was to be applied at specific times each day. The registered staff did not consistently document whether the resident received the specific treatment as per their care plan 11 times during the identified time period.

Interview and review of the TAR with RPN #103 stated that registered staff were to sign the TAR each time a specific treatment was applied and confirmed that the above treatments should have been applied at specific times each day and were not documented in the TARS as outlined above.

B) The plan of care for resident #046 indicated they had an area of altered skin integrity to an identified body part, and a specific treatment in place for the area of altered skin integrity. Review of the TAR for an identified month, revealed the treatment was to be applied at a specific time of day. Interview with PSW #141 stated that they applied the treatment at an identified time of day. Interview with RPN #142 and review of the TAR confirmed that registered staff did not consistently document that the resident had the treatment applied on three identified dates in 2017. [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 #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that outdoor windows, that were accessible to residents, were screened and restricted to 15 centimetres (cm).

On an identified date, an identified room was observed, by Inspectors #518 and #168, with the entrance doors open and the room accessible to residents. This room was equipped with awning style windows which opened to the outside. One of the windows was opened, by Inspector #518, and was not restricted and opened greater than 15 cm.
On an identified date, the Administrator was informed of the window not being restricted, by Inspector #168. The Administrator indicated that they would contact Maintenance staff regarding the issue.
On an identified date, the ESM confirmed, to Inspectors #518 and #168, that not all of the awning style windows, in the identified room, were restricted to open less than 15 cm, as required.
On an identified date, the Maintenance Lead, confirmed, to Inspector #518, that on an identified date, outdoor windows in the identified room, were not restricted to prevent opening greater than 15 cm.

Not all outdoor windows, which were accessible to residents, were restricted to 15 cm. [s. 16.]

WN #9: 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. (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 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 that a written record was kept as required.

On request the home provided a copy of their most recent quarterly review of all medication incidents and adverse drug reactions. This review was identified by the DOC to be conducted as part of the Health Professional Advisory Committee (HPAC), an interdisciplinary review. The DOC identified that the last HPAC meeting was conducted on an identified date. It was confirmed by the DOC that the home had scheduled a subsequent meeting in an identified month; however, it was cancelled due to an emergency and was not rescheduled by the meeting chair.

A review of the most recent HPAC Meeting Minutes included a review of the medication incidents and adverse drug reactions for two identified months in 2017, only and not for a quarter, as confirmed by the DOC following a review of the meeting minutes. The HPAC Meeting Minutes from an identified month, included a Pharmacy Report, which identified that the home had a total of nine incidents in two identified months in 2017. The DOC provided a copy of the hand written Medication Incidents - Facility Summary sheet for the same time period, which identified a total of eight incidents. The DOC was not able to explain the discrepancy in the two reports, for the same time period. [s. 135. (3)]

Issued on this 19th day of December, 2017

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

Original report signed by the inspector.