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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_606563_0003	004227-17	Resident Quality Inspection

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

KENSINGTON VILLAGE
1340 HURON STREET LONDON ON N5V 3R3

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

MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), JENNA BAYSAROWICH (667), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 6, 7, 8, 9, 10, 13, 14, 15, 16 and 17, 2017

The following intakes were completed within the RQI:
034887-16 - 2729-000007-16 - Critical Incident related to falls
018465-16 - IL-45224-LO - Complaint related to allegations of suspected abuse
034696-16 - IL-48485-LO - Complaint related to allegations of suspected abuse
031619-16 - IL-47756-LO - Complaint related to admission refusal
004076-17 - IL-49456-LO- Complaint related to safety concerns
019286-16 - Follow Up Inspection related to Residents' Council

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nursing Director of Care, the Resident Assessment Instrument Coordinator, the Physiotherapist, the Physiotherapist Assistant, the Director of Facility Services, one Housekeeper, the Director of Food Services, the Registered Dietitian, one Dietary Aide, the Occupational Therapist, the Client Care Coordinator for Staff Relief, the Pharmacy Manager, the Supervisor Technician, seven Registered Nurses, one former Registered Nurse, nine Registered Practical Nurses, one Registered Practical Nurse Student, 15 Personal Support Workers, two Behavioural Supports Ontario Personal Support Workers, one Personal Support Worker Student, 40 plus residents and three plus family members.

The Inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
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
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **10 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 57. (2)	CO #001	2016_326569_0010	630

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

For the purposes of the Act and this Regulation, "altered skin integrity means potential or actual disruption of epidermal or dermal tissue."

Record review of the "KV Skin/Wound Assessment V 1.0" completed in PointClickCare (PCC) documented altered skin integrity for three residents. A referral to "Registered Dietitian Regarding Skin/Wound Area For Nutritional Interventions" was answered 'No" for all skin assessments completed for these three residents.

The RPN shared that an initial and weekly wound assessment should be completed for altered skin integrity.

During a telephone interview, the Registered Dietitian (RD) said referrals were received

through PCC and the RD received 30-40 referrals per month.

The Resident Assessment Instrument Coordinator (RAI-C) acknowledged that there was no documented evidence that the weekly wound assessments had been completed until the assessment indicated “Skin/Wound Area Healed (discontinue weekly assessment protocol on area)". The RAI-C also acknowledged that there were no initial or weekly assessments of the altered skin integrity for the residents.

The Director of Food Services (DFS) shared that a Dietary Referral would be completed by the registered staff, then the DFS or the RD would read the 24 hour shift report and implement a nutritional intervention as appropriate. The DFS shared there were no "Dietary Referral" progress notes related to the altered skin integrity for these residents and shared that there were no dietary referrals completed related to the residents altered skin integrity.

Record review of the Skin & Wound Care Program policy NS-II-420 effective October 2012 stated residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will have a skin assessment completed by registered staff; be assessed by the Registered Dietitian and reassessed at least weekly.

The licensee failed to ensure that initial and weekly wound assessments were completed for three residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Registered staff did not complete a dietary referral at the time the altered skin integrity was discovered, therefore those residents were not assessed by a Registered Dietitian.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was widespread for three of three residents during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 25, 2016 as a Voluntary Plan of Correction during Resident Quality Inspection #2016_326569_0010. [s. 50. (2) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A resident reported that they had concerns with how they were being treated by a staff member. The resident said they had spoken to a nurse and a Personal Support Worker (PSW) in the home on multiple occasions regarding their concerns. The resident said the way they were being treated was affecting them emotionally but they were fearful to bring forward the concerns to management in the home as they thought it may affect the care they received.

Former Registered Nurse (RN) shared that the resident had told them concerns about how they were being treated by a staff member and said that they sent a letter to the Administrator regarding the concerns that the resident was yelled at by the RN. Former RN said that no management in the home spoke with them regarding the letter or the concerns that they had brought forward regarding the treatment of the resident by a staff member.

The PSW shared that the resident had come to them with concerns on multiple occasions with how a staff member was treating them. The PSW said they had observed this staff member speaking to the resident in a harsh way. The PSW said that they did not bring forward the concern to their supervisor or the management in the home because the resident had told them they did not want them to bring forward the concern on their behalf due to feeling afraid. The PSW said that the concerns brought forward by the resident could fall within the PSW's understanding of potential verbal or emotional abuse based on the training received in the home.

The investigation documentation provided by the Administrator consisted of one hand written note of concerns related to a staff member. No further documentation within this note or in separate documents was provided to the inspectors.

The home's policy titled "Resident Abuse and Neglect" with effective date August 2012 stated under "Reporting of Incidents" that "all employees must report any and all cases of suspected or actual elder abuse or neglect immediately to the Director or Nursing and/or Administrator." The policy stated under "Investigating" that "the Director of Nursing and/or Administrator will interview all involved parties and maintain a written, taped or video record of the same" and they were to "utilize Resident Abuse incident checklist to ensure all processes are completed." The policy stated that "interventions will be put in place to prevent a recurrence of the incident."

The Administrator said they did not follow-up with the resident regarding the concern or implement any interventions apart from letting the resident know that they could talk to them if they had any further concerns. The Administrator acknowledged to the Inspector that the home's "Resident Abuse and Neglect" policy was not complied with regarding concerns about alleged verbal abuse that were brought forward to staff by the resident.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of abuse of a resident by anyone was immediately investigated and that appropriate action was taken in response to every such incident.

The home's policy titled "Resident and Abuse and Neglect" with effective date August 2012 defined verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of wellbeing, dignity or self-worth that is made by anyone other than a resident."

A resident reported to the Inspector that they had concerns with how they were being treated by a staff member. The resident said they had spoken to a nurse and a Personal Support Worker (PSW) in the home on multiple occasions regarding their concerns. The resident said the way they were being treated was affecting them emotionally but they were fearful to bring forward the concerns to management in the home as they thought it may affect the care they received.

Former Registered Nurse (RN) told the Inspector that the resident had told them concerns about how they were being treated by a staff member and said that they sent a letter to the Administrator regarding the concerns that the resident was yelled at by the RN. Former RN said that no management in the home spoke with them regarding the letter or the concerns that they had brought forward regarding the treatment of the

resident by a staff member.

The Administrator shared that they had received a letter from the former RN through email and said they thought they had spoken to the resident after receiving the letter and thought they had made some notes in their notebook regarding the concern. The Administrator said there had been other issues going on with the former RN and that the RN sent a letter of resignation at the same time as the letter regarding the concerns for the resident was received.

Review of the letter written by the former RN showed it was addressed to the Administrator and identified the topic as a complaint.

The Administrator said they found the documentation in their notebook regarding the conversation with the resident and acknowledged to the inspector that they had met with this resident eight days after they received the letter about the concern. The Administrator said they did not speak to the former RN regarding the concern or interview any other staff in the home regarding the concern. The Administrator said they did not follow-up with the resident regarding the concern until until several months later and that they had left it with the resident to see them if they had any further concerns.

The Administrator acknowledged that they did not immediately investigate allegations in a letter that would suggest potential abuse and also acknowledged they did not take appropriate action in response to an incident that had been brought to their attention as they did not follow-up with the resident after the initial meeting or with the RN that was involved in the incident.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 23. (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 every alleged incident of abuse of a resident by anyone is immediately investigated and that appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment which included the assessment of any risks related to nutritional care for all residents whenever these was a significant change in the resident's health condition.

The clinical record for the resident showed that the resident was to continue with the recommended diet to minimize further risk.

The Registered Dietitian (RD) documented an annual assessment which identified that the resident was receiving a particular type of diet. This assessment did not include documentation of an assessment by the RD and no other assessment notes were observed as having been completed.

The RD shared that the registered staff in the home were to send the referrals if a resident had particular difficulties. The RD said their practice was to document their

assessments in a progress note. The RD reviewed the clinical record for the resident and said that they did not complete an assessment as part of the annual review and they had not completed an assessment for the resident since. The RD said they had not received a referral for a particular concern for the resident and they were not aware that they had recommendations from acute care.

The home's policy titled "Nutritional Care – Referrals to Registered Dietitian" with effective date October 2012, stated "when a resident requires an assessment between scheduled assessments a Dietary Referral form will be completed by the Nurse, Physician and/or Director of Dietary Services." This policy also identified that the registered nursing staff would provide the RD with a referral when a resident had "difficulty chewing or swallowing" and "a change in health status with nutritional implications".

The Director of Food Services (DFS) said it was the expectation in the home that the RD would assess residents with difficulties and that the nursing staff in the home would send referrals to notify the DFS and the RD of diet recommendations made when a resident received acute care.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 26. (4) (a),s. 26. (4) (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 a registered dietitian who is a member of the staff of the home completed a nutritional assessment which included the assessment of any risks related to nutritional care for all residents whenever these is a significant change in the resident's health condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint policy was complied with.

The resident was observed with a particular assistive device in place and engaged. The resident told Inspector that they always had their assistive device in place and that they were not able to remove their device.

The Personal Support Worker (PSW) shared that the resident wore a restraint regularly and that the resident was unable to remove the the restraint themselves.

The Resident Assessment Instrument Coordinator (RAI-C) acknowledged that restraint was not included in the resident`s care plan.

The Occupational Therapist (OT) stated that the resident's assistive device was not implemented based on their recommendation, that they would not recommend the use of a particular restraint unless the resident was in a vehicle, and that this particular restraint was not effective for positioning.

The Registered Practical Nurse (RPN) told Inspectors that the resident was not monitored for restraint use. The RPN acknowledged that a restraint was not included in the resident's care plan or physician's orders. The RPN stated the home's process for restraint use was that there was a physician's order for the restraint, the order was to be entered into the electronic Medication Administration Record (MAR), the restraint use information was entered into the care plan and that restraint use was monitored and signed off on by registered staff. The RPN acknowledged that the resident's assistive device was not being monitored by staff as it had not been entered into the MAR.

The home's expectation according to procedures outlined in the home's policy titled, "Safety Devices - Reducing the Use of Restraints" policy number NS-II-412 effective

December 2012 was the following:
• A restraint assessment was to be completed prior to restraints being ordered.
• A Restraint Review Committee was to meet monthly.
• Physiotherapy/Occupational Therapy were to be engaged in the evaluation of the resident for restraint alternatives.
• Staff were to ensure that in every instance of restraint use there was a specific physician order for restraints and that the plan of care addressed how the use of restraints was to be monitored as well as when and how restraint reduction was attempted.

The clinical record for the resident showed the following:
• No documented assessment of the assistive device observed during the time of inspection.
• No data found for the past 30 days in Point of Care (POC) for monitoring of the assistive device.
• That there was no documented evidence at the time of the inspection of a physician's order, consent form, assessment for the restraint and no information regarding the restraint in the care plan.

The Director of Care (DOC) told Inspectors that the home’s expectation was that all restraint use was to be documented in the resident’s care plan. The DOC stated that when a resident was unable to consistently undo the assistive device on their own, the device was considered a restraint. The DOC stated that the home’s expectation regarding use of the device as a restraint was that a restraint assessment was completed, alternatives to the restraint were considered and documented in Point Click Care, consent was obtained by resident or their Substitute Decision Maker (SDM), the reason for the device use was documented, a physician order was completed, a restraint was included in the resident care plan and that there was ongoing monitoring daily and reassessment of the restraint by registered staff.

The RAI-C stated that their expectation was that the resident would have had an assessment done prior to the order for their restraint to justify reason for its use.

The DOC acknowledged that the home’s restraint application consent form titled, “Kensington Village Nursing Home Restraint Application Form” was unclear as it did not identify the specific restraint that was being consented for. The DOC stated that the home ’s expectation was that the physician’s order for the resident’s assistive device was entered into the electronic record and acknowledged that it had not been entered. The

DOC acknowledged that the physician's order for the resident's assistive device did not identify duration or reason for use and stated their expectation was that a physician's order was obtained prior to restraints being applied and that this was not identified. The DOC acknowledged the home's policy titled, "Safety Devices – Reducing the Use of Restraints Policy" stated, "physician verbal order will be obtained within 12 hours of the restraint application and documented on the Resident's record". The DOC stated they believed this was a "gap" in the policy and that applying a restraint to a resident prior to obtaining a physician's order was only appropriate if the resident was at serious risk of harm. The DOC stated they were not aware of the existence of a Restraint Review Committee in the home.

Based on these interviews, observations and the clinical record review, the licensee has failed to ensure that the policy titled, Safety Devices – Reducing the Use of Restraints, was complied with.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 29. (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 their restraint policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Assistance Services Device (PASD) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

The Inspector observed the resident with a Personal Assistance Services Device (PASD) in use.

The resident told the Inspector that the PASD was regularly in use.

The Personal Support Worker (PSW) told the Inspector that the resident's PASD was in use due to risk.

The PSW told the Inspector that the resident's PASD was in use to help prevent risk to the resident. When asked where staff would find information regarding the PASD for the resident, the PSW told the Inspector that they would look in the tasks section of Point of Care (POC). The Inspector observed the PSW reference POC and the PSW demonstrated that there was no information included in POC regarding the resident's PASD or its function.

The Registered Practical Nurse (RPN) acknowledged to the Inspector that the resident was currently using the PASD. The RPN acknowledged that there was no information in the resident's care plan regarding the PASD.

The RPN shared that the resident's PASD was not considered a restraint as it was used for positioning. The RPN told the Inspector that the PASD should have been added into the resident's care plan under Personal Assistance Services Device (PASD) section.

The Resident Assessment Instrument Coordinator (RAI-C) shared that the resident's PASD was not being used as a restraint and that the home did not complete assessments for this particular PASD when the PASD was not being used as a restraint. The RAI-C acknowledged that the resident would not be able to get out of their PASD under specific conditions. The RAI-C shared that if a PASD was used in a particular way, it would be classified as a restraint but that they were not sure if staff were applying the PASD for the resident to be considered a restraint. The RAI-C stated that staff would find information regarding the PASD in the kardex. The Inspector observed the RAI-C reference the resident's care plan and kardex and the RAI-C acknowledged that there

was no information regarding PASD. The RAI-C told the Inspector that the home did not have a policy for restraint or PASD assessments based on a conversation the RAI-C had with the Administrator.

The resident was observed with a particular assistive device in place and engaged. The resident told the Inspector that they always had their assistive device in place and that they were not able to remove their device.

The Personal Support Worker (PSW) shared that the resident wore a restraint regularly and that the resident was unable to remove the the restraint themselves.

The Occupational Therapist (OT) during a telephone interview shared that the resident's PASD was ordered by the home without consulting the OT. The OT stated that the physical condition of the resident changed and that staff were concerned for the resident's safety. The OT shared that when they assessed the resident, they found that the resident was better positioned with the PASD in use.

The clinical record for the resident showed the following:
• a progress note stated that a request was submitted for a PASD for the resident.
• a progress note stated that the resident received a new assistive device for trial.
• an "Occupational Therapy Note" did not include any reference to the PASD recommendation.
• there was no documented evidence of a physician's order for the PASD, any information regarding the PASD in their care plan was absent, no assessment of the PASD, and no information regarding the PASD in Point of Care (POC) or the kardex.

The Director of Care (DOC) told Inspectors that the PASD was a form of restraint because it could prevent a resident from getting out of the wheelchair. The DOC stated that the PASD was used for the resident's safety and positioning. The DOC stated that the home's expectation was that an assessment was done for the use of the PASD, a physician's order was completed, consent would be obtained from the resident or Substitute Decision Maker (SDM), and that there was ongoing monitoring and revaluation of the PASD by registered staff.

Based on these interviews, observations and the clinical record review, the licensee failed to ensure that the PSAD was used only when included in the plan of care.

The severity was determined to be a level 2 as there minimal harm or potential for actual

harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 7, 2015 as a Voluntary Plan of Correction during Critical Incident Inspection #2015_229213_0046, on October 7, 2015 as Voluntary Plan of Correction during Critical Incident Inspection # 2015_303563_0041, and on April 25, 2016 as a Voluntary Plan of Correction during Resident Quality Inspection #2016_326569_0010. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a Personal Assistance Services Device (PASD) described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A progress note documented in PointClickCare (PCC) identified that the resident was lowered to the floor by staff, and the registered staff documented that the resident was complaining of pain from the fall.

The Registered Practical Nurse (RPN) explained that if a resident had a fall, they would complete a post fall assessment under the assessments tab in PCC. The RPN acknowledged that if a resident was lowered to the floor by staff, it was still considered a fall and a post fall assessment would be required to be completed.

Review of the resident's health care records showed that no post fall assessment was completed related to the incident where staff assisted the resident to the floor.

The Kensington Village Fall Prevention and Management Program policy number NS-II-265, with an effective date of October 2012, defined a fall as "any unintentional change in position where the resident ends up on the floor, ground or lower level". The policy also stated that a fall must be considered a fall if "a resident has lost balance and would have fallen if staff did not intervene," and if "the fall results in an injury" the charge nurse would complete the post fall assessment.

The Registered Nurse (RN) reviewed the progress note and considered the incident a fall, and acknowledged that a post fall assessment should have been completed.

The Director of Care stated that if a resident was assisted to the floor by staff, it was considered a fall and that it was the expectation that a post fall assessment be completed.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 49. (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 when a resident had fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: written approaches to care, reassessment and identification of behavioural triggers that may result in responsive behaviours, to prevent, minimize, or respond to the responsive behaviours; resident monitoring and internal reporting protocols; and protocols for the referral of residents to specialized resources where required.

The Personal Support Worker (PSW) shared that the resident was regularly exhibiting responsive behaviours and that the resident had exhibited responsive behaviours while staff were providing care. The PSW stated that a specific strategy staff had used to respond to the resident's behaviours was not always effective. The PSW was unable to identify triggers for the resident's behaviours other than stating the resident had a specific diagnoses. When asked how new staff would know how to respond to and manage the resident's behaviours, the PSW stated new staff would not be able to provide care for the resident on their own and that they would have to ask regular staff about strategies to manage the resident's care, as strategies were not listed in the kardex.

The clinical record for the resident showed the following:
• No behavioural triggers were documented for the resident in the care plan.
• No resident specific interventions or strategies for managing the resident's behaviours were documented in the care plan.
• No observed behavioural assessments completed apart from the Mini Mental Status Exam (MMSE) and Resident Assessment Instrument Minimum Data Set (RAI-MDS).
• No observed documentation by Behavioural Supports Ontario (BSO).
• No observed documentation of a referral of the resident to specialized resources found in the electronic medical record.

The Personal Support Worker (PSW) who was a part of the home's BSO team shared that they did not complete formal assessments for residents referred to BSO and that they tried different strategies to manage behaviours. The PSW stated residents referred to BSO in the home received BSO support as required and that there were no structured BSO visits for these residents. The PSW stated there were no specific behavioural triggers identified for the resident that they were aware of.

The Director of Care (DOC) shared that there was no formal assessment process once a resident was referred to BSO. The DOC stated the process in place for BSO referrals was that staff made a verbal referral to the two PSWs on the BSO team and then those

PSWs used a trial-and-error method for developing interventions for managing resident behaviours. The DOC acknowledged that there was no formal assessment completed by BSO for the resident and that specific behavioural triggers were not identified.The DOC also acknowledged that they were not aware of a BSO policy in the home. The DOC shared that the BSO interventions that were trialled for residents were not being documented in residents' care plans and that there was no formal process in place for communicating these interventions with the frontline staff. The DOC stated the process for making a referral to external resources and acknowledged that the home's "Managing Responsive Behaviours Program" policy number LTC NS-II-411, did not contain updated written protocols for referring residents to specialized resources within the home and outside of the home, as the external services for managing behaviours that were utilized by the home were not outlined in the policy.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 53. (1)]

2. The licensee has failed to ensure that at least annually, the written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other; written strategies, including techniques and interventions, to prevent, minimize, or respond to the responsive behaviours; resident monitoring and internal reporting protocols; and protocols for the referral of residents to specialized resources where required, were evaluated and updated in accordance with evidence-based practices.

The home's policy titled, "Managing Responsive Behaviours Program", policy # LTC NS-II-411, dated December 2012, stated that the Resident Quality Committee (RQC) was to evaluate the Responsive Behaviours Program annually.

The DOC acknowledged that the home's policy titled, "Managing Responsive Behaviours Program", policy number LTC NS-II-411, did not contain updated written protocols for referring residents to specialized resources within the home and outside of the home, as the external services for managing behaviours that were being utilized by the home were not outlined in the policy.

The DOC acknowledged that there was no documented evidence that the home's

Responsive Behaviours Program was evaluated and updated in 2016. and also acknowledged that they were not certain when the "Managing Responsive Behaviours Program" policy was last revised.

Based on a review of the home's policy titled, "Managing Responsive Behaviours Program" and an interview conducted with the DOC, the home failed to update their Responsive Behaviours Program and policy.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 53. (3) (b)]

3. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified; strategies were developed and implemented to respond to these behaviours; and actions were taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented.

The Personal Support Worker (PSW) told the Inspector that the resident sometimes exhibited responsive behaviours.

The Registered Nurse (RN) shared that this resident had a history of responsive behaviours but they were not aware of any responsive behaviours for the resident at the time of the interview.

The PSW shared that the resident regularly exhibited responsive behaviours while staff were providing care. The PSW stated that the specific strategy staff had used to respond to the resident's behaviours, but that it was not always effective. The PSW was unable to identify triggers for the resident's behaviours other than stating the resident had a specific diagnoses. When asked how new staff would know how to respond to and manage the resident's behaviours, the PSW stated new staff would not be able to provide care for the resident on their own and that they would have to ask regular staff about strategies to manage the resident's care, as strategies were not listed in the kardex.

The Resident Assessment Instrument Coordinator (RAI-C) shared that the home's process when resident behaviours were noticed to have escalated was that a referral

was made to the resident's physician and that the resident's plan of care was updated with interventions on managing the behaviours. The RAI-C shared that a referral was made to the resident's physician when the behaviours escalated. When asked about the resident's specific behavioural triggers, these triggers were noted in the resident's care plan, the RAI-C stated that the home did not include behavioural triggers in the care plan and only included interventions. When asked what staff would do if the full time RPN was not working and they wanted to know about the resident's behavioural triggers, the RAI-C stated they did not know what to tell the Inspector and that staff could read the nursing reports to find out about resident behaviours.

The RN told Inspectors that there were no specific triggers identified for the resident's behaviours other than a specific diagnoses. When asked about interventions for managing the resident's behaviours, The RN stated the resident had more behaviours during a specific time of day. When asked how staff knew how to approach the resident for care, the RN stated they just knew the resident and that the resident would let staff know if they did not want to be bothered. The RN stated they expected to find strategies for managing the resident's care in the kardex.

The Personal Support Worker (PSW) who was part of the home's Behavioural Supports Ontario (BSO) team told the Inspector that they did not complete formal assessments for residents referred to BSO. The PSW stated residents referred to BSO in the home received BSO support as required and that there were no structured BSO visits for these residents. The PSW stated there were no specific behavioural triggers identified for the resident that they were aware of.

The clinical record in PCC for the resident showed the following:
• Resident Assessment Instrument Minimum Data Set (RAI-MDS) Behavioural Resident Assessment Protocol (RAP) identified that during the observation period, the resident exhibited responsive behaviours that were not easily altered. This RAP also stated that the resident's behavioural symptoms had changed.
• RAI-MDS Behavioural RAP identified that during the observation period the resident exhibited responsive behaviours that were not easily altered. This RAP also stated that the resident's behavioural symptoms had changed.
• Progress notes documented responsive behaviours for the resident.
• An "MD Progress Note" documented that the resident's medications were changed. No reference to any behavioural services referrals made.
• A Mini Mental Status Exam (MMSE) assessment indicated cognitive impairment.
• A "Behaviours" section was included in the resident's care plan which identified

behavioural interventions.
• No behavioural triggers were identified for the resident in their care plan.
• No observed documentation by Behavioural Supports Ontario (BSO) in the resident's electronic progress notes or assessments.

The DOC shared that the process for BSO referrals was that once a BSO referral was made, two specific PSWs were most responsible for implementing BSO interventions and that the interventions were documented on the "BSO Resident Documentation Form". The DOC stated the BSO referral and follow-up process was currently being modified by the DOC and a registered staff member and that a formal process for BSO assessments was not in place.

The DOC shared that the two specific PSWs used a trial-and-error method to find out what strategies helped manage resident behaviours and that until a more formal process was developed, the PSWs were responsible for creating interventions. The DOC acknowledged that the resident had not been formally assessed by BSO and the DOC was not aware of any specific behavioural triggers for the resident. The DOC shared that the BSO interventions in place for the resident were identified on the "BSO Resident Documentation Form". When asked how these interventions were communicated to staff, the DOC stated there was no formal process for communicating the interventions other than that a verbal conversation between nursing staff was had. The DOC stated the goal was to include BSO interventions in resident care plans, however the DOC acknowledged that was not being completed at the time of this inspection.

Based on the observations and clinical record review it was identified that the resident had been demonstrating responsive behaviours, staff had not documented the identified triggers in the plan of care, strategies had not been implemented consistently to respond to the behaviours, and actions were not taken to assess and document the resident's responses to the interventions.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following are developed to meet the needs of residents with responsive behaviours: written approaches to care, reassessment and identification of behavioural triggers, resident monitoring and internal reporting protocols and protocols for the referral of residents to specialized resources where required; to ensure that at least annually, the written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, written strategies including techniques and interventions, to prevent, minimize, or respond to the responsive behaviours, resident monitoring and internal reporting protocols and protocols for the referral of residents to specialized resources where required, are evaluated and updated in accordance with evidence-based practice; and to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified; strategies are developed and implemented to respond to these behaviours; and actions are taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

The former Registered Nurse (RN) stated during an interview that they did not receive in-person abuse training upon hire and that they completed online abuse training via Surge learning modules. Review of the home's abuse training records documented that the RN first completed Surge abuse training module two months after being hired.

The Inspector interviewed Personal Support Worker (PSW) regarding abuse and neglect training. The PSW stated that they first received abuse and neglect training four months after being hired.

The Inspectors interviewed the Administrator who stated that abuse and neglect training was conducted via Surge Learning modules utilized by staff to complete the training and was paid for by the home. The Administrator provided abuse training records including training completion dates for all nursing staff. The Administrator stated that ten PSWs did not complete the training for 2016. The Administrator provided these staff members with an extension to complete the training by the end of January 2017. The Administrator stated these staff members did not complete the training by this extension deadline, which resulted in verbal disciplinary action. The Administrator provided the Inspectors with corresponding documentation of verbal disciplinary action letters dated March 1, 2017.

The Administrator stated the home's expectation was that all newly hired staff were to complete abuse training prior to the end of five orientation shifts where they were mentored by staff.

The licensee has failed to ensure that all staff members received abuse and neglect training prior to the end of their orientation shifts.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 76. (2) 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 received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities, to be implemented voluntarily.

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).
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).
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any resident restrained by a physical device had the physical device applied by staff in accordance with the manufacturer's instructions.

The Inspector observed the resident with a physical device in place on multiple occasions.

Inspectors observed the resident with a device in use and was not secured. The Inspector observed the resident move the device out of place. The Inspector observed the PSW ask the resident to remove the device and the resident moved the device out of place. The PSW was observed to reapply the device to secure placement.

The resident told the Inspector that they always used their device and that they were able to remove the device but had difficulty reapplying it without assistance.

The PSW told the Inspector that they had witnessed the resident remove the device.

The Registered Practical Nurse (RPN) told the Inspector that the resident was capable of removing the device.The RPN shared that they did not believe the resident's device was considered to be a restraint and that the resident was able to remove the device themselves.

The Resident Assessment Instrument Coordinator (RAI-C) shared that the resident's device was implemented as a safety measure. The RAI-C stated that there were no assessments completed for Personal Assistance Services Devices (PASDs) or restraints used in the home and that the home did not have a policy for either of these assessments.

During a telephone interview, the Occupational Therapist (OT) shared that the resident's device was not initially implemented based on the OT's recommendation and that the device was ordered by the resident's physician.

The Registered Nurse (RN) told Inspectors that the resident's device was implemented to help manage the resident's behaviours. The RN stated that when the device was applied the resident was still able to move the devcie out of place.

The clinical record for the resident showed the following:
• A progress note which stated that the resident received a device as per the physician's order.
• An "MD Progress Note" stated that the physician wondered if the resident would benefit from a device.
• A physician order stated the resident was to have a device applied.
• A consent form stated the resident's family member provided verbal consent for use of the restraint.

• A progress note documented that a device was used for the resident and that it was considered to be a restraint.
• A progress note stated the resident attempted to take off the device and the DOC suggested that the suggested that the device be removed for the day.
• Care plan note identified the device as a restraint and stated it was to be applied as per the orders.
• No assessment of the device was located during time of inspection.
• No data found for the past 30 days in Point of Care (POC) for monitoring of the device.

The Director of Care (DOC) stated that the resident's device should have been locked in place and should have been secure enough to keep the device in place without risking injury to the resident.

Based on these interviews, observations and the clinical record review, the licensee has failed to ensure that the resident's device identified as a restraint by the home was applied by staff in accordance with the manufacturer's instructions.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 110. (1) 1.]

2. The licensee has failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act that staff only applied the physical device that was ordered or approved by a physician or registered nurse in the extended class; that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose; and that the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

The resident was observed with a Personal Assistance Services Device (PASD) engaged. The Inspector observed Personal Support Worker (PSW) ask the resident if they were able to remove their PASD and the resident replied by asking the PSW to remove it. The Inspector observed that the resident was not able to remove their PASD until the PSW provided the resident with a verbal cue to remove the PASD by following

specific instructions. The Inspector observed the PSW reapplying the resident's PASD.

The resident shared that they used a PASD and they were not able to remove their PASD.

The PSW shared that the resident used a PASD regularly and that the resident was unable to remove the PASD themselves.

The PSW shared that the resident was able to remove their PASD in the past, however the resident could no longer remove it at the time of the inspection.

The Registered Practical Nurse (RPN) shared that the resident was able to remove their PASD on their own and that they thought the resident’s PASD was not a restraint.

The Resident Assessment Instrument Coordinator (RAI-C) shared that they were not certain if the resident had a PASD in place as the resident had ripped it off in the past. The RAI-C stated the resident was able to undo the PASD themselves. The RAI-C acknowledged that the PASD was not included in the resident’s care plan.

The Occupational Therapist (OT) stated that the resident’s PASD came standard with their mobility device. The OT said that they would not recommend use of a this particular PASD unless the resident was in a vehicle and that these PASDs were not effective for positioning.

The Registered Nurse (RN) shared that there was a PASD in place for the resident due to safety concerns and that they thought the resident would probably be able to remove the PASD if they wanted to.

The PSW shared that the resident used a PASD.

The Registered Practical Nurse (RPN) told Inspectors that the resident usually had a PASD in place and that the resident was able to remove the PASD themselves. The RPN stated that the PASD was not included in the resident's care plan or physician’s orders and acknowledged that they were not signing off on any restraints for the resident.

The clinical record for the resident showed the following:
• A progress note stated that a PASD was utilized by the resident.
• A progress note stated that a PASD was being utilized for the resident and that they

refused to keep the PASD on.
• A progress note stated that the resident tore apart their PASD.
• A "Fall Incident Note" documented that a PASD was utilized for the resident as a safety intervention.
• An "Occupational Therapy Note" documented that the Occupational Therapist (OT) assessed the resident for a new mobility device and did not reference the resident's use of a PASD.
• That there was no documented evidence at the time of the inspection of a physician's order, assessment for the seat belt and no information regarding a PASD in the plan of care.

The Director of Care (DOC) told Inspectors that the home's expectation was that all PASD use was to be documented in the resident's care plan even if the staff in the home did not consider the PASD to be a restraint and that the PASD use was continuously reassessed and monitored by registered staff to determine if resident was still able to remove the PASD or not. The DOC stated that when a resident was unable to consistently undo the PASD on their own, the PASD was considered a restraint. The DOC stated that the home's expectation regarding use of a PASD as a restraint was that a restraint assessment was completed, alternatives to the restraint were considered and documented in PointClickCare, consent was obtained by resident if able or their Substitute Decision Maker (SDM), the reason for restraint use was documented, a physician order was completed, the restraint was included in the resident care plan and that there was ongoing monitoring daily and reassessment of the restraint by registered staff.

Based on these interviews, observations and the clinical record review, the licensee has failed to ensure that the resident's PASD was ordered by a physician or registered nurse in the extended class prior to the application of the seat belt, that the resident was monitored while restrained by the PASD at least every hour by a member of the registered nursing staff and that the resident's condition was reassessed and the effectiveness of the PASD was evaluated by a physician, registered nurse in the extended class attending the resident or a member of the registered nursing staff at least every eight hours and at any other time when necessary based on the resident's condition or circumstances.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three

years. [s. 110. (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 resident restrained by a physical device had the physical device applied by staff in accordance with the manufacturer's instructions and to ensure that where a resident was being restrained by a physical device under section 31 of the Act that staff only applied the physical device that is ordered or approved by a physician or registered nurse in the extended class; that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose; and that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstance, to be implemented voluntarily.

WN #11: 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 involving 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.

The RN shared that for the medication incident reports for the three residents, the family and the physician were not contacted and would not be because there were no adverse drug reactions.

During a telephone interview, the Operational Pharmacist and Pharmacy Manager shared that pharmacy would receive a faxed copy of the medication incident report from the home completed by the DOC or management of the home. The Pharmacist also shared that only some of the medication incident reports were passed on to the physician for follow up and a signature.

The RPN shared that the physician or the resident and/or family were not contacted upon the discovery of the medication error identified in the medication incident reports for the three residents and would only contact them if there was a negative outcome to the resident or if an adverse drug reaction had occurred. The RPN shared that if the physician or family were notified it would be documented as a progress note.

Record review of the residents' progress notes for those residents involved in the ten medication incidents did not document the notification of the family and nine of the ten medication incidents had no documentation in the progress notes identifying that the incidents were reported to the physician.

Record review of the ten medication incident reports between September 1 and December 1, 2016 did not document that the resident and/or family were notified of the medication incidents and nine of the ten incidents had no documentation under the "Physician Response". There was no negative outcome to the residents and there was no adverse drug reaction documented related to the ten medication incidents. The RN and former DOC completed the "Manager's Response" section of the medication incidents for nine of the ten incidents.

During a telephone interview, RN and former DOC shared that the physician would be contacted if there was an adverse drug reaction or at the discretion of the registered staff or manager. RN and former DOC shared that the notification of the physician was not always required and that the registered staff or management would contact family to report the incident if there was a negative outcome for the resident or if an adverse drug reaction occurred and said the incidents were never reported to the physician for the incident reports the RN reviewed while the RN was the interim DOC. The RN shared that a progress note in PointClickCare (PCC) would document the follow up with the

physician and the resident and/or family.

The licensee failed to ensure that every medication incident involving a resident was reported to the resident, the resident's SDM and the resident's attending physician.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [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 under clauses (a) and (b).

Record review of the ten medication incident reports between September 1 and December 1, 2016, did not document the follow up with the employees involved and there was no documented corrective action.

The RPN shared that management did not follow up with them related to the medication incident report for the resident. The RPN remembered the medication incident, but that management did not follow up and the RPN was not instructed related to corrective action to prevent reoccurrence. The RPN also reviewed the medication incident report for the resident and shared that there was no follow up with management and this was the first time the RPN had heard about this.

During a telephone interview, the RN and former DOC shared that the follow up with staff would be documented on the medication incident reports in the “Manager Response” of actions taken and that this follow up documentation would not be recorded anywhere else in the employees’ file.

The licensee failed to ensure that all medication incidents were analyzed, corrective action was taken and a written record was kept of everything required.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 135. (2)]

3. The licensee failed to ensure that a quarterly review was 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, any changes and improvements identified in the review were implemented, and a written record was kept of everything provided for in clause (a) and (b).

The most recent Professional Advisory Committee (PAC) Meeting dated December 1, 2016 was attended by the home's interdisciplinary team, including the Pharmacist. The PAC meeting minutes documented 10 medication errors between September 1 and December 1, 2016. There were no other details related to the medication incidents and no reports were provided by pharmacy.

The Director of Care (DOC) acknowledged that the PAC meeting on December 1, 2016, 10 medication errors were documented and were not analyzed. The DOC also acknowledged that a quarterly review was not undertaken of all medication incidents and adverse drug reactions between September 1 - December 1, 2016 and changes and improvements were not identified in the review and a written record was not kept of everything.

The licensee failed to ensure that a quarterly review was 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, any changes and improvements identified in the review were implemented, and a written record was kept of everything for the 10 medication incident reports completed between September 1 and December 1, 2016.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [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 involving 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; to ensure 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; and to ensure that 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, any changes and improvements identified in the review are implemented, and a written record wis kept of everything, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Skin and Wound Care Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices and a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Record review of the "Skin and Wound Care Management Program Evaluation" form stated the review of service was from January 1 - December 31, 2016 and the review was completed by the Administrator and the RPN who were “all in attendance”. The date of the review was March 6, 2017. The program evaluation was incomplete for the review of specific clinical indicators over the past year that were outlined on the evaluation. The summary of the changes made over the past year with dates of those changes were absent from the evaluation.

During a telephone interview, the RPN shared they were the only Wound Champion for the home. The RPN shared they did not attend a meeting on March 6, 2017 to discuss the criteria of the skin and wound care management program evaluation and had no other input in the evaluation. The RPN could not recall the last time the skin and wound care evaluation was completed. The RPN shared they were not working March 6, 2017.

The Director of Care acknowledged that the skin and wound care management program evaluation was incomplete and that the names of the persons who participated in the evaluation were incorrect, and a summary of the changes made and the date that those changes were implemented were absent from the evaluation.

The licensee failed to ensure that the Skin and Wound Care Management Program was evaluated and updated at least annually that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 30. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to approve the applicant's admission to the home unless the home lacked the physical facilities necessary to meet the applicant's care requirements, the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements, or that circumstances existed which were provided for in the regulations as being a ground for withholding approval.

The Administrator stated that a resident was refused admission because of behaviours that the home could not manage. The Administrator explained however that the resident would have been best located on the top floor of the home because there were safety

interventions in place.

The Administrator said that the home had staff trained in dealing with responsive behaviours.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 44. (7)]

2. The licensee has failed to ensure that a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, was given to the persons described in subsection (10) when withholding approval for admission.

Review of complaint action line # IL-47756-LO showed that the home had withheld approval for admission of a resident. The home provided a copy of the letter that stated the home was "unable to provide the resources necessary to care for this applicant at this time." The letter continued to say that the information provided in the application to the home indicated care requirements for the resident were more than their current resources allow.

The letter written by the Administrator to the complainant did not provide a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care.

The Administrator acknowledged that the letter was vague, and that the Community Care Access Centre (CCAC) had recommended changes to their notification letter, and offered to provide a new template.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 44. (9) (b)]

3. The licensee has failed to ensure that a written notice setting out the contact information for the Director was given to the persons described in subsection (10) when withholding approval for admission.

The complainant, related to complaint action line # IL-47756-LO, indicated that they had

received a letter from the home indicating why the resident was withheld approval for admission.

Review of the admission refusal letter did not identify the contact information for the Director.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 44. (9) (d)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 86. Accommodation services programs

Specifically failed to comply with the following:

s. 86. (2) Where services under any of the programs are provided by a service provider who is not an employee of the licensee, the licensee shall ensure that there is in place a written agreement with the service provider that sets out the service expectations. O. Reg. 79/10, s. 86 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where services under any of the programs were provided by a service provider who was not an employee of the licensee, the licensee shall ensure that there was in place a written agreement with the service provider that sets out the service expectations.

The Director of Facility Services and the Director of Care stated that Dura Med was their preferred vendor for cleaning wheelchairs in the home.

The Inspector and the Director of Facility Services called the Dura Med Representative and were informed that there was no written agreement with the service provider that set out the service expectations.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 86. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures were developed and implemented for cleaning of the home, including common areas and their furnishings.

The Inspector made observations of three Personal Support Worker (PSW) chairs in the first floor dining room area. The Inspector noted that the chairs were visibly soiled and stained around the base, legs, and wheels. The Inspector observed that five PSW chairs on the second floor dining room area were also visibly soiled and stained in the same manner as those on the first floor.

The Inspector observed two bedside tables utilized by residents for meals in the first floor dining room that had extensive stains along the base, legs, and wheels.

The Director of Facility Services stated that it was the responsibility of the dietary department to clean the tables and chairs in the dining rooms. The Director of Facility Services stated that there was no process in place for cleaning dining room chairs.

The Director of Food Services provided a dining room cleaning schedule that outlined tasks for dietary aides to complete and initial when required. Review of the cleaning schedule showed that there were no tasks related to cleaning the base of chairs or bedside tables. The Director of Food Services acknowledged that the chairs and bedside tables were quite dirty after completing an observation. The Director of Food Services stated that there was no process in place to clean the chairs and bedside tables, and that they were required to be cleaned.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 87. (2) (a)]

2. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures were developed and implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

The Inspector observed a resident sitting in a transfer chair with residue on the silver frame and foot rests and dirt on the front wheels.

Review of progress notes in PointClickCare (PCC) indicated that the resident had utilized the transfer chair since last year.

The Director of Facility Services explained that on a weekly basis, a representative of Dura Med would come and clean the wheelchairs of residents. The cleaner would come with a list of residents with wheelchairs that needed to be cleaned, but the Director of Facility Services had not seen or kept the schedule.

The Dura Med Representative stated that they came to the home twice a week to clean wheelchairs, and that all wheelchairs were completed at least once a month. Dura Med would indicate a wheelchair was completed by checking off on a sticker that was applied on the base of the wheelchairs. The representative explained that they leave a list of the residents at the nursing desk of which wheelchairs were completed, but was unable to

provide a tracking list of all wheelchairs cleaned in February.

The Registered Nurse (RN) explained that they would provide a list of residents with wheelchairs to the Dura Med Representative. There was no schedule provided to the representative, but rather the representative chose which wheelchairs to clean and left them a note stating what was completed. The RN told the Inspector that they were not retaining the records of which wheelchairs were completed by the Dura Med Representative, and that there was no schedule in place.

The Dura Med Representative observed the resident's transfer chair that did not have a Dura Med sticker applied, and acknowledged that they had not cleaned it since the resident started using it late last year. Additionally, there was no schedule or records kept of which wheelchairs were cleaned to indicate that the resident was even identified as a resident with a chair that needed to be cleaned.

The Director of Facility Services stated that all wheelchairs including transfer chairs should be regularly cleaned. The Director of Care acknowledged that there was no schedule keeping track of which chairs were cleaned, and that while there was a process in place for cleaning wheelchairs, it had not been implemented.

The severity was determined to be a level 1 as there minimal risk. The scope of this issue was a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. [s. 87. (2) (b)]

Issued on this 24th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), JENNA BAYSAROWICH (667), NEIL KIKUTA (658)
Inspection No. / No de l'inspection :	2017_606563_0003
Log No. / Registre no:	004227-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 1, 2017
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 1340 HURON STREET, LONDON, ON, N5V-3R3
LTC Home / Foyer de SLD :	KENSINGTON VILLAGE 1340 HURON STREET, LONDON, ON, N5V-3R3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Ducharme

To SHARON FARMS & ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

Order / Ordre :

The licensee must achieve compliance to 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,
(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

Specifically, the home will:
a) Develop and implement a process for completing skin assessments,
b) Develop and implement a tracking and auditing system for assessments, documentation and strategies for all altered skin integrity in the home,
c) Educate all nursing staff related to the process for Registered Dietitian referrals.

Grounds / Motifs :

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

For the purposes of the Act and this Regulation, "altered skin integrity means potential or actual disruption of epidermal or dermal tissue."

Record review of the "KV Skin/Wound Assessment V 1.0" completed in PointClickCare (PCC) documented altered skin integrity for three residents. A referral to "Registered Dietitian Regarding Skin/Wound Area For Nutritional Interventions" was answered 'No" for all skin assessments completed for these three residents.

The RPN shared that an initial and weekly wound assessment should be

completed for altered skin integrity.

During a telephone interview, the Registered Dietitian (RD) said referrals were received through PCC and the RD received 30-40 referrals per month.

The Resident Assessment Instrument Coordinator (RAI-C) acknowledged that there was no documented evidence that the weekly wound assessments had been completed until the assessment indicated “Skin/Wound Area Healed (discontinue weekly assessment protocol on area)". The RAI-C also acknowledged that there were no initial or weekly assessments of the altered skin integrity for the residents.

The Director of Food Services (DFS) shared that a Dietary Referral would be completed by the registered staff, then the DFS or the RD would read the 24 hour shift report and implement a nutritional intervention as appropriate. The DFS shared there were no "Dietary Referral" progress notes related to the altered skin integrity for these residents and shared that there were no dietary referrals completed related to the residents altered skin integrity.

Record review of the Skin & Wound Care Program policy NS-II-420 effective October 2012 stated residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will have a skin assessment completed by registered staff; be assessed by the Registered Dietitian and reassessed at least weekly.

The licensee failed to ensure that initial and weekly wound assessments were completed for three residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Registered staff did not complete a dietary referral at the time the altered skin integrity was discovered, therefore those residents were not assessed by a Registered Dietitian.

The severity was determined to be a level 2 as there minimal harm or potential for actual harm. The scope of this issue was widespread for three of three residents during the course of this inspection. There was a compliance history of this legislation being issued in the home on April 25, 2016 as a Voluntary Plan of Correction during Resident Quality Inspection #2016_326569_0010. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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