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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 3, 2018	2017_703625_0015	019363-17	Resident Quality Inspection

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road Box 179 Wawa ON P0S 1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

KATHERINE BARCA (625), DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 26 to 28 and October 3 to 5, 2017.

An additional intake completed during the Resident Quality Inspection (RQI), log #022439-17, was related to a Follow-up to Compliance Order #001 issued during inspection #2017_669642_0011, regarding the Long-Term Care Homes Act, 2007, s. 6. (1) (c) which requires every licensee of a long-term care home to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse/Charge Nurse (RN/CN), the Coordinator of Maintenance, the Physiotherapy (PT) Assistant and the Director of Patient Care Services/Administrator/Director of Nursing and Personal Care (DONPC).

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspectors also reviewed relevant health care records, meeting minutes, incident reports and numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During inspection #2017_669642_0011 Compliance Order #001 was issued pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s. 6. (1) (c).

The licensee was ordered to ensure that resident #007's plan of care set out clear directions to staff and others who provided direct care to the resident, specifically with regards to the resident's use of bed side rails, with a compliance date of September 15, 2017.

During a review of the home's discharged resident report, resident #007 was identified as no longer residing in the home. However, additional non-compliance, including non-compliance regarding bed side rail use, was identified during this inspection pursuant to s. 6. (1) (c).

During an interview with Inspector #625 on a date in the fall of 2017, RPN #103 identified that resident #006 did not have a particular intervention in place to address a specific concern.

Inspector #625 reviewed resident #006's health care record and identified:
- The current care plan indicated that staff were to provide the resident with a particular intervention related to nutrition care;
- The current LTC Diets list indicated the resident was to receive the particular intervention related to nutrition care;
- A Long Term Care Fluid Intake sheet dated specific dates in the fall of 2017, listed the resident was to receive the particular intervention related to nutrition care in one area of the sheet and a different intervention in another area of the sheet; and
- A Long Term Care Fluid Intake sheet dated different specific dates in the fall of 2017, did not list the particular intervention related to nutrition care on the sheet but listed a different intervention on another area of the sheet.

During interviews with RPNs #103 and #104, they acknowledged that the Long Term Care Fluid Intake sheets dated specific dates in the fall of 2017, contained details related to the particular intervention related to nutrition care and that the direction regarding the intervention was not clear on the documents.

During an interview, Registered Dietitian (RD) #105 acknowledged that the plan of care, specifically the Long Term Care Fluid Intake sheets for specific dates in the fall of 2017, were not consistent in identifying the nutrition intervention in place.

During an interview with Inspector #625, the RPN Long-Term Care (LTC) Team Lead #101 acknowledged that Long Term Care Fluid Intake sheets for specific dates in the fall of 2017, did not provide clear direction with respect to the nutrition intervention in place. [s. 6. (1) (c)]

2. Resident #009 was identified as having had a nutrition related concern according to the 90 day Resident Assessment Instrument - Minimum Data Set (RAI-MDS) relative to the admission assessment.

(a) Inspector #577 conducted a record review of resident #009’s weight history and found a significant weight change between two months in 2017.

During a record review of the RD's orders, Inspector #577 identified an order for a particular nutrition intervention at a specific frequency. A second order dated two weeks after the previous order, identified that the intervention was to be completed at a different specific frequency.

A record review of resident #009’s current care plan identified that the nutrition intervention was to be completed at both of the specified frequencies as per the dietitian.

A further review of resident #009’s health care record identified that the particular nutrition intervention at a specific frequency had not been completed as ordered over 14 consecutive dates in the spring and summer of 2017.

Inspector #577 interviewed the RPN LTC Team Lead #101 who reported that the nutrition related intervention for resident #009 was not completed at a specific frequency in one month of 2017, and the nutrition related intervention in the resident's care plan was unclear.

(b) During a record review of the RD's order, Inspector #577 identified orders for a nutrition related intervention at two specific frequencies. The orders were dated three different specific dates in the spring and summer of 2017.

A record review of resident #009’s care plan in place at time of their admission identified the resident was to have the nutrition related intervention at a specific frequency as per the RD's recommendation.

A further record review of resident #009’s updated care plan interventions identified the intervention was to be provided to the resident at a different specific frequency.

Inspector #577 conducted a review of resident #009’s Medication Administration Records (MARs) and found that the nutrition related intervention was not listed for two consecutive months in the spring of 2017. The Inspector found that the intervention at a specific frequency was initiated on the MARs on a particular date in the spring of 2017 and changed to a different frequency six days later.

Inspector #577 reviewed the home's policy titled "Oral Nutrition Supplements", last revised December 2016, which indicated:
- an order for a specific nutrition supplement was to be written on the Physician's Order form by the RD and the order was to be processed by nursing who would transcribe the order to the MARs. The order was to specify the volume and frequency of the chosen supplement; and
- the RD was to complete a progress note and the LTC Lead would update the resident's care plan about the order for the nutritional supplement.

Inspector #577 spoke with RPN #103 who reported that the particular nutrition related intervention was not initiated for resident #009 until a specific month in the spring of 2017.

Inspector #577 spoke with the RPN LTC Team Lead #101 who reported that the nutrition related intervention was not listed on resident #009's MARs for two consecutive months in 2017, and should have been. They confirmed that the plan of care was unclear with respect to the provision the intervention to resident #009. [s. 6. (1) (c)]

3. Inspector #625 observed bed side rails raised on resident #004's bed functioning as potential restraints.

Inspector #625 reviewed resident #004's health care record including:
- the current Long Term Kardex/ALC (undated) that identified the resident used "siderails";
- the current Consent to Use of Restraint(s) that identified the resident used "side rails x 4 for bed";
- the current CCRS MDS Kardex Report, that identified the resident used "full bed rails";
- the Restraint Assessment/Physician Order and Individual Restraint Re-Assessment Form, both dated a particular date in the summer of 2017, that identified the resident used "siderails x 4";
- the Bed System Entrapment Risk Assessment dated a particular date in the winter of 2017, that indicated the resident used full, horizontal left and right bed rails. The assessment contained undated hand written entries "[change] to Quarter Rails" and "Quarter rails in place" and one hand written entry "Reviewed. No changes made"; and
- the current care plan that identified the resident used "4 side rails when is [sic] bed" and "uses bed rails".

During a phone interview with Inspector #625, the RPN LTC Team Lead #101

acknowledged that resident #004's plan of care identified different bed side rails in use as "side rails", "full bed rails", "4 side rails", "side rails x 4", "uses bed rails", full left and right rails and quarter rails. The Team Lead acknowledged that resident #004's plan of care required revision to provide clear direction to staff, as it contained references to different types of bed side rails in use. [s. 6. (1) (c)]

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

Resident #010 was observed by Inspector #577 to have a specific medical condition.

Inspector #577 reviewed resident #010's care plan which indicated that the resident had a specific medical condition and required a particular intervention that staff were to document on the flow sheet daily.

A review of resident #010's Seven Day Observation and Monitoring forms for two consecutive months in 2017, identified that:
- in one month, the intervention was not documented as being done on 64 per cent of the days; and
- in the second month, the intervention was not documented as being done on 36 per cent of the days.

During an interview with Inspector #577, PSW #106 reported that they had not performed the intervention with resident #010 that day.

During an interview with Inspector #577, RPN #107 reported that the resident's involvement in a particular activity of daily living (ADL) was the intervention.

Inspector #577 spoke with RPN LTC Team Lead #101 who reported that nursing staff were required to perform the intervention as per the care plan. They further confirmed that performing the intervention required staff to complete specific activities. [s. 6. (7)]

5. Inspector #625 observed that resident #011 required specific grooming. Inspector #577 also observed the resident to require specific grooming on two additional dates.

Inspector #577 reviewed resident #011's care plan which indicated the resident required staff to perform the required grooming.

During an interview with Inspector #577, RPN #108 reported that resident #011 performed the grooming activity with staff assistance.

Inspector #577 spoke with RPN #113 and RPN #109 who both reported that resident #011 completed the particular grooming activity themself. RPN #109 reviewed resident #011's care plan and the RPN acknowledged that the care plan identified that the resident required assistance by staff with the grooming activity. [s. 6. (7)]

6. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #625 observed resident #004 with a safety device engaged while using a particular mobility aid.

A review of resident #004's health care record included:
- the current care plan that identified the resident used a safety device while using a mobility aid;
- Restraint Records (used for hourly documentation of the application, repositioning, release, monitoring and reason for specific safety device use) that identified the resident tolerated the use of the safety device on seven consecutive dates in the summer and fall of 2017; and
- a Seven Day Observation & Monitoring Form (used for shiftly documentation of specific safety devices in use), that did not identify the resident used the safety device on the seven consecutive dates in 2017.

During a phone interview with Inspector #625, the RPN LTC Team Lead #101 confirmed that resident #004 used the safety device while using a mobility aid and that the Restraint Record reflected that the resident used the safety device on the seven consecutive dates in 2017. The Team Lead stated that, although staff had applied the safety device on those dates, they had not documented the application of the safety device as required on the Seven Day Observation & Monitoring Form from for the seven consecutive dates. [s. 6. (9) 1.]

7. Inspector #625 observed resident #001 with a safety device applied while using a particular mobility aid.

A review of resident #001's health care record included:
- the current care plan that identified the resident required a safety device at all times

when using a mobility aid;
- Restraint Records (used for hourly documentation of the application, repositioning, release, monitoring and reason for specific safety device use) that identified the resident tolerated the use of the safety device on eight dates (seven of which were consecutive) in the summer and fall of 2017; and
- Seven Day Observation & Monitoring Forms (used for shiftly documentation of specific restraints in use) that did not identify that the resident used the safety device on the eight dates in 2017.

During an interview with Inspector #625, the RPN LTC Team Lead #101 confirmed that resident #001 required a safety device when using a mobility aid, that the use of the safety device was included in the resident's plan of care, that the Restraint Records for the eight dates in 2017 identified that the resident had the safety device in use on each date. The Team Leader stated that, although staff had applied the safety device on those dates, they had not documented the application of the device as required on the Seven Day Observation & Monitoring Forms on the eight dates. [s. 6. (9) 1.]

8. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During an interview with Inspector #577, resident #009 reported that they experienced a particular medical condition on a specific part of their body. In addition, the resident's most recent RAI-MDS assessment identified that the resident experienced the particular medical condition with specific characteristics.

Inspector #577 reviewed resident #009's current care plan and identified that the resident had a physiotherapy assessment dated a particular date in the spring of 2017 and was provided with an intervention by the Physiotherapy Assistant at a specific frequency.

During a record review of Physiotherapy assessments, the Inspector found that resident #009 was assessed on two consecutive dates in the spring of 2017, and had then consistently refused the intervention.

During an interview with resident #009, they reported to Inspector #577 that they had not participated in the intervention for multiple months.

Inspector #577 reviewed a physiotherapy form which indicated that resident #009 had an

assessment completed on a particular date in the spring of 2017 and had consistently refused to participate in the intervention beginning six days after the assessment date.

Inspector #577 conducted a review of the home's policy titled "Care Plans", last revised November 14, 2016, which indicated that on admission, a 24 hour care plan would be developed and within 14 days, a care plan would be developed. The policy identified that the care plan would be monitored on a daily basis to identify changing personal needs, to evaluate treatment outcomes and to update treatment requirements, and that continuity of care would be maintained by the interdisciplinary team following care plans and reviewing care plans quarterly.

During an interview with Inspector #577, Registered Nurse/Charge Nurse (RN/CN) #102 reported that it was the responsibility of the RPN LTC Team Lead to update resident care plans.

During an interview with Inspector #577, the RPN LTC Team Lead #101 reported that resident #009 did not participate in the intervention, and that the care plan had not been updated or reassessed to reflect the resident's change in needs. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers'

instructions.

Inspector #625 observed resident #001's bed to have bed rail(s) in use. Both bed rails had been modified using material not manufactured for that purpose.

RPN #110 stated to Inspector #625 that resident #001's bed side rails were modified using the material which the staff had been directed to apply. The RPN stated that they had cut the material with scissors to obtain the required fit.

During interviews with Inspector #625, RPN #111 stated that resident #001's bed side rails were modified using the material. The RPN stated that the side rails had previously been modified on both sides but that it made it difficult to raise and lower the rails so the staff removed part of the material on the side of the more frequently adjusted rail.

During interviews with Inspector #625, the RPN LTC Team Lead #101 stated that resident #001 used bed side rails which had been modified using the material, that the bed system had failed an entrapment zone test the previous year and that the modification using the material was put in place as a temporary measure to mitigate the risk of entrapment. The RPN stated that the resident had previously used a differently configured bed side rail system and that the material used to modify the bed rails was not a product that was designed to modify to bed rails in that manner.

During an interview with the Coordinator of Building Maintenance, they stated to Inspector #625 that the bed in use by resident #001 had failed entrapment zone testing between the side rails and the mattress and that the material had been used to modify the bed side rails by the nursing staff to address the entrapment risk. The Coordinator also stated that the manufacturer of the bed systems produced particular items for use with the bed system; however, the material currently used to modify the bed side rails was not a particular item provided by the manufacturer.

During an interview with Inspector #625, the Administrator/Director of Nursing and Personal Care (DONPC) stated that the material had been used to modify the bed side rails used by resident #001 as the bed had failed bed system entrapment zone testing the previous year. They also stated that the manufacturer of the material intended the use of the material to be for a purpose other than modification of the bed rails. The Administrator/DONPC stated that the resident had previously used a differently configured bed rail system with a particular item purchased specifically to modify the bed rails, and that the current material used was not manufactured to modify bed rails.

The document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" dated June 21, 2006, developed by the Hospital Bed Safety Workgroup, defined a bed system as a bed frame, mattress, bed rails, as well as other accessories that were compatible with each other and advised to check with the manufacturer for compatibility of bed system components. The guide indicated that the use of any mitigation strategy or accessory should not increase the risk of injury to patients or health care providers and that the use of accessories, such as mattress overlays, should not alter conformance of the bed system to the recommended dimensions or create a new risk of entrapment or other injury. The guide further stated that, after a change was made to the bed system, the change should be reassessed to ensure the changes had not adversely affected any functioning of the bed system or caused an additional risk of injury, and to use appropriate clinical judgement when selecting or using any accessory device. [s. 23.]

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 that ensures that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

Inspector #625 observed resident #004 using a safety device with a mobility aid. On another date the resident was again observed to be using the mobility aid. At another time, Inspector #625 observed resident #004 to use the mobility aid in a particular manner.

During an interview with the Inspector, resident #004 stated that staff used the mobility aid in a particular manner and had last used it in such a manner the previous date.

A review of resident #004's health care record included:
- Seven Day Observation & Monitoring Forms that indicated, under section P) Devices and Restraints, the resident used a mobility aid with a particular characteristic on six specific dates during the summer and fall of 2017; and
- the current CCRS MDS Kardex Report; the current care plan; the Restraint Assessment/Physician Order dated a specific date in the summer of 2017; the Individual Restraint Re-Assessment Form dated a specific date in the summer of 2017; and the Consent to Use of Restraint(s) dated a specific date in the fall of 2016, all of which did not identify that the resident used the mobility aid in a particular manner.

During a phone interview with Inspector #625, the RPN LTC Team Lead #101 acknowledged that resident #004 used a mobility aid with a particular characteristic, that staff used the mobility aid in a particular manner at times, the resident was restrained when the mobility aid was used in a particular manner and the use of the mobility aid in that manner was not included in the resident's plan of care. The Team Lead stated that the home had not considered mobility aids used in a particular manner to be physical restraints. [s. 31. (1)]

2. Inspector #625 observed resident #001 use a mobility device in a particular manner.

A review of resident #001's health care record included:
- Seven Day Observation & Monitoring Forms that indicated, under section P) Devices and Restraints, the resident used a mobility device in a particular manner on two specific dates in the summer and fall of 2017; and
- the current CCRS MDS Kardex Report; the current care plan; the Restraint Assessment/Physician Order dated a specific date in the summer of 2017; the Individual Restraint Re-Assessment Form dated a specific date in the summer of 2017; the Consent to Use of Restraint(s) dated a specific date in the summer of 2017, all of which did not identify that the resident used the mobility device in a particular manner.

During an interview with Inspector #625, the RPN LTC Team Lead #101 acknowledged that resident #001 used a mobility device with a particular characteristic, that staff used the mobility aid in a particular manner at times, that the resident was restrained when the mobility aid was used in a particular manner and that the use of the mobility aid in that manner, which restrained the resident physically, was not included in the resident's plan of care. [s. 31. (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 that ensures that restraining of resident #001, resident #004 and all residents in the home being restrained by a physical device, as described in paragraph 3 of subsection 30 (1), occurs only if the restraining of the residents is included in the residents' plans of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no device provided for in Ontario Regulation 79/10 was used to restrain a resident.

Ontario Regulation 79/10 s. 112 indicates that restricted devices that limit movement, for the purpose of section 35 of the Act, include any device with locks that can only be released by a separate device, such as a key or magnet.

Inspector #625 observed resident #004 with a safety device engaged while using a mobility aid.

The Inspector reviewed the resident's health care record including:
- a Consent to Use of Restraint(s) document dated a particular date in the fall of 2016, that indicated the consent was valid for one year. The document identified that resident #004 used a particular safety device when using a mobility aid that required a separate device to release it; and
- an Individual Restraint Re-Assessment Form dated a specific date in the summer of 2017 that indicated the safety device requiring a separate device to release it was removed and a different safety device was to be used.

During a phone interview with Inspector #625, RPN LTC Team Lead #101 acknowledged that resident #004 had a prohibited device as a restraint for multiple months in 2016 and 2017. [s. 35. (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 that ensures that no device provided for in the regulations, identified in Ontario Regulation 79/10, s. 112, is used by resident #004 or by any resident in the home, to restrain the resident, to be implemented voluntarily.

WN #5: 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 has 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.

On three separate dates Inspector #625 observed altered skin integrity on two particular locations of resident #003's body.

A review of resident #003's health care record by Inspector #625 included:
- the current care plan, that indicated that resident #003 had a history of altered skin integrity to the particular parts of their body related to a medical condition and that interventions were required for the altered skin integrity;
- a Long Term Care Annual Medical History & Physical dated a specific date in the fall of 2016, that identified the resident had a medical condition that was present;
- a Long-Term Care Interdisciplinary Team Conference Record dated a specific date in the summer of 2017, that identified the resident had an ongoing altered skin integrity problem related to specific skin integrity issues and had a treatment ordered for use as required; and
- Long Term Care Quarterly Skin Integrity Assessments dated two dates in 2017 that indicated the resident had altered skin integrity.

The Inspector was not able to locate a skin assessment completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, that had been completed related to the resident's altered skin integrity, on particular parts of their body where altered skin integrity had been observed, in the resident's health care record.

During an interview with Inspector #625, RPN #113 stated that the resident had altered skin integrity on a location on their body that was being treated, but they were not able to locate a completed skin assessment which used a clinically appropriate assessment instrument specifically designed for skin and wound assessment for resident #003's altered skin integrity.

During interviews with the RPN LTC Lead #101 on two specific dates, they stated to Inspector #625 that the areas of altered skin integrity on the resident's specific body parts had been diagnosed as a medical condition and that a prescribed treatment was in use. They indicated that the home had not completed any assessments on the resident's altered skin integrity using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

During an interview with Inspector #625, the Administrator/DONPC stated that, although the resident's health care record indicated the presence of the altered skin integrity, a skin assessment had not been completed by the registered staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment for resident #003's altered skin integrity. [s. 50. (2) (b) (i)]

2. Inspector #625 observed altered skin integrity on a particular location on resident #002's body. On two other specific dates, the Inspector observed a medical treatment in place in the location of the previously observed area of altered skin integrity.

A review of resident #002's health care record by Inspector #625 included the following:
- a Long Term Care Annual Medical History & Physical dated a specific date in the summer of 2017, that indicated the resident had a medical condition on a particular body part;
- the current care plan, that had identified a medical condition on a particular body part, that a medical procedure had been completed and that a related intervention would be required;
- a Long Term Kardex/ALC document that identified, on a specific date in the fall of 2017,

the presence of a altered skin integrity on a part of the resident's body and that a particular medical treatment was to occur; and
- Nurses' Notes entries dated two separate dates in the summer and fall of 2017, that identified that the resident had a medical condition on a particular body part, that the physician had reassessed the resident’s area and that a medical procedure would be conducted.

The Inspector was not able to locate a skin assessment completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, that had been completed related to resident #002's altered skin integrity in the resident’s health care record.

During an interview with Inspector #625, RPN #113 stated that the resident currently had an area of altered skin integrity on a particular location on their body.

During interviews with RPN LTC Team Lead #101 on two specific dates, they stated to Inspector #625 that resident #002 had an alteration in the skin integrity on a particular location on their body; a medical procedure had occurred on a specific date in the fall of 2017, and the physician had provided treatment instructions. They indicated that the home had not completed assessments on the resident’s altered skin integrity, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

During an interview with Inspector #625, the Administrator/DONPC stated that, although the resident’s health care record indicated the presence of the altered skin integrity on the particular location on the resident's body, a skin assessment had not been completed by the registered staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment for resident #002's altered skin integrity. [s. 50. (2) (b) (i)]

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 that ensures that residents #002, #003 and all other residents in the home exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act and included on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs.

Inspector #625 observed resident #004 to have a specific medical condition.

A review of resident #004's health care record included:
- a Personalized PT Program for resident #004 dated a specific date in the fall of 2016, that listed various exercises to be completed at specific frequencies;
- Physiotherapy Department LTC Client Stat Forms dated a specific date in the fall of 2016, that referred to the exercise sheets and indicated that the physiotherapy staff

should try to work with the resident at a specific frequency; and
- Physiotherapy Department LTC Client Stat Forms that identified the resident participated in a specific number of physiotherapy sessions of specific durations. The forms indicated that:
(a) during one month in 2017, the resident was approached to participate in the physiotherapy program a specific number of times (the resident participated 33 per cent of the times and refused to participate 67 per cent of the times);
(b) during the next consecutive month in 2017, the resident was approached to participate in the physiotherapy program a specific number of times (the resident participated 36 per cent of the times and refused to participate 64 per cent of the times); and
(c) during the next consecutive month in 2017, the resident was approached to participate in the physiotherapy program a specific number of times (the resident participated 60 per cent of the times and refused to participate 40 per cent of the times).

During an interview with Inspector #625, the Physiotherapy (PT) Assistant #114 stated that, as per the Physiotherapy Department Inpatient Assessment Form, the last time the Physiotherapist had assessed resident #004 was on a specific date in the fall of 2016. The PT Assistant stated that the personalized physiotherapy program outlined for resident #004 would realistically take two to three times as long as the duration of the longest session they had engaged the resident in. The PT Assistant stated they had specific duration and frequency limitations to complete physiotherapy for all of the residents requiring it on the unit. The PT Assistant stated that they did not follow all of the exercises and would pick and chose which exercises to complete as they did not have enough time to complete them all with the resident. The PT Assistant stated that they did not complete the exercises with resident #004 at any specific frequency, and that they were lucky to have the resident participate in the program on a lesser specific frequency. The PT Assistant acknowledged that the resident had only been approached to participate in the physiotherapy program on 17 per cent of the days in a recent month in 2017. [s. 59. (a)]

2. Resident #001 was identified to have had a change in locomotion according to the most recent RAI-MDS assessment relative to the previous assessment.

A review of resident #001's health care record included:
- a Personalized Exercise Program dated a specific date in the summer of 2015, that listed a specific number of exercises to be completed at a specific frequency. A hand-written notation on the sheet dated a specific date in the winter of 2016, listed additional

exercise(s) to be complete at a specific frequency;
- Trigger Listing and RAP Information dated a specific date in the summer of 2017, that identified the resident had been participating in the physiotherapy program at a specific frequency with the Physiotherapy Assistant; and
- Physiotherapy Department LTC Client Stat Forms which identified that, with respect to the physiotherapy program, during a month in 2017, the resident was approached and participated a specific number of times; during the next consecutive month in 2017, the resident was approached and participated a specific number of times; and during the next consecutive month in 2017, the resident was approached and participated in the program a specific number of times. The form identified that the resident last participated in the physiotherapy program on a specific date in the summer of 2017.

During an interview with Inspector #625, the RPN LTC Team Lead #101 stated that resident #001 had experienced changes in their ability to ambulate over a period of months, that the resident participated in the physiotherapy exercises at most at a specific frequency, and that the resident's health care record indicated that they last participated in physiotherapy exercises 17 days prior to the interview.

During an interview with Inspector #625, PT Assistant #114 stated that the resident was not receiving physiotherapy at the frequency identified on their most recent Personalized Exercise Program dated the winter of 2016. The PT Assistant confirmed that the resident was approached and participated in the program on seven per cent of the days in one month in 2017; on 16 per cent of the days in the previous month in 2017; and on 23 per cent of the days in the month prior to the previous month. The PT Assistant confirmed that resident #001 was not receiving physiotherapy services on-site on an individualized basis based on the resident's assessed care needs. [s. 59. (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 that ensures that therapy services for resident #001, resident #004 and all residents of the home are arranged or provided under section 9 of the Act that include, on-site physiotherapy provided to residents on an individualized basis or in a group setting based on the residents' assessed care needs, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, that all assessment, reassessment and monitoring, including the resident's response were documented.

On a particular date, Inspector #577 observed resident #012 with a safety device and bed rails engaged. During the inspection, Inspector #577 observed resident #012 with a safety device engaged daily while using a mobility aid.

A record review was conducted, by Inspector #577, of resident #012's current care plan which contained the following interventions:
- the resident required bed rails in bed;
- the resident used a safety device when using their mobility aid and staff were to ensure

the safety device met a particular characteristic, as per the manufacturer's instructions;
- staff were to document daily on restraint sheets; and
- staff were to reassess the restraint use every eight hours.

Inspector #577 conducted a record review of resident #012's RAI-MDS assessment dated a specific date in the summer of 2017, which indicated, under the category devices and restraints, that bed rails and a safety device were used daily.

A record review of resident #012's Restraint Records for three consecutive months was conducted by Inspector #577. The record indicated the resident used a safety device when using a mobility aid and bed rails when in bed. A further review identified missing restraint monitoring documentation on four days in one month, three days in the next month and three days in the following month.

Inspector #577 reviewed the home's policy titled, "Minimizing Restraining of Residents and the use of Personal Assistance Service Devices" last revised May 2017. The policy indicated that staff were to document every hour on the restraint monitoring record, and every two hours when the restraint was released and the resident was repositioned. A review of a documentation guideline for the Restraint Record indicated that staff were to document every hour, and eight hour checks were required to be documented using a staff initial.

During an interview with Inspector #577, RPN #111 reported that staff were required to document on the residents' Restraint Records every hour, document eight hour checks, and document the release and repositioning of the resident every two hours.

Inspector #577 spoke with RPN LTC Team Lead #101, who reported that resident #012 used bed rails when in bed and a safety device when using a mobility aid, which were considered restraints. The Team Lead was not able to locate restraint monitoring documentation on the Restrain Records for the dates and times previously identified by Inspector #577. The Team Lead reported that there was no restraint documentation completed for resident #012 with respect to the assessment, reassessment and monitoring, including the resident's response to the restraints in use, on the dates and times identified. [s. 110. (7) 6.]

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 that ensures that every use of a physical device to restrain resident #012, or any resident in the home, under section 31 of the Act is documented and, without limiting the generality of this requirement, ensures that all assessment, reassessment and monitoring, including the resident's response are documented, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee has 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 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.

Ontario Regulation 79/10 describes a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or

distributing of a drug, or the transcribing of a prescription, and includes:
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident; or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

Inspector #577 conducted a review of the medication incident reports with a focus on the following three narcotic medication incidents:
- on a specific date in the spring of 2017, the incorrect dosage of a medication was given to resident #003. The report indicated that the resident, the resident's substitute decision-maker (SDM) and the pharmacy service provider were not notified of the incident;
- on a specific date in the spring of 2017, resident #009 received an extra dose of a prescribed medication. The report indicated that the pharmacy service provider was not notified of the incident and the physician was not notified until three days after the incident occurred; and
- on a specific date in the summer of 2017, a prescribed medication was given earlier than scheduled. The report indicated that the resident, the resident's SDM, the physician and the pharmacy service provider were not notified of the incident.

For all three medication incidents, immediate actions taken to assess and maintain the residents' health were not documented on the incident report or in the nursing notes.

Inspector #577 reviewed the home’s policy titled "Medication Incidents" last revised September 9, 2017, which indicated that medication incidents would be reported to the prescribing physician, noted in the nursing notes and reported to the resident, or to the person(s) legally acting on behalf of the resident. A medication incident report form was to be completed and forwarded to the Director of Patient Care Services.

During an interview with RPN LTC Team Lead #101, they reported to the Inspector that when a medication incident occurred, staff were required to document the error on a medication error form, and forward the form to the Administrator and call the physician.

During an interview with Inspector #577, the Administrator/DONPC confirmed that the resident, the resident's SDM, the physician and the pharmacy service provider had not been notified of two of the incidents, and immediate actions had not been documented for all three incidents. [s. 135. (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 that ensures 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
(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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (1) Every licensee of a long-term care home shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident. O. Reg. 79/10, s. 241 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one non-interest bearing trust account was established and maintained at a financial institution in which the licensee deposited all money entrusted to the licensee’s care on behalf of a resident.

Inspector #625 reviewed the LTCH Licensee Confirmation Checklist Admission Process completed by the home on September 26, 2017, and identified that the home had responded “N/A” (not applicable) to the question pertaining to the admission package of information containing financial information including trust account information.

During an interview with Inspector #625, family member #115 stated that resident #001 did not have a trust account with the home but kept their money in a secured box in the medication room. The family member stated that they had provided money in this manner upon the resident’s admission years prior and had last deposited hundreds of dollars into the account years prior but did not know how much money was left as they had never received a statement of the balance or transactions that had occurred. They stated that they had not been approached by the home to set up a trust account and did not know that this could occur.

During an interview with RPN LTC Team Lead #101, they stated that residents’ money was kept in a safe in the medication room which nurses accessed and provided to residents when requested. The LTC Team Lead confirmed with the Inspector that two out of four residents' balances audited by Inspector #625, or 50 per cent of the audited residents, had discrepancies between the amount of money in the safe and the current balances listed on their tracking record.

On September 26, 2017, Inspector #625 interviewed the Administrator/DONPC regarding the home’s response on the LTCH Licensee Confirmation Checklist Admission Process completed by the home on September 26, 2017. The Administrator/DONCP stated that the home did not have trust accounts in place for residents. During a second interview with the Administrator/DONPC on October 3, 2017, they confirmed that the home kept residents' money in a safe in the medication room when it was entrusted to the care of the home on behalf of a resident. [s. 241. (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 that ensures that the home establishes and maintains, for resident #001 and all resident's in the home who have entrusted money to the licensee's care on behalf of a resident, at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of a resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming.

Inspector #625 observed resident #001 with a medical condition on four specific dates.

A review of resident #001's health care record included documentation related to the provision of physiotherapy and included a Physiotherapy Department Inpatient Assessment Form dated a specific date in the summer of 2015; a Personal Exercise Program dated a specific date in the summer of 2015, and updated on a specific date in the spring of 2016; and PT Department LTC Client Stat Forms with the most recent entry dated a specific date in the fall of 2017. The physiotherapy assessment and exercise program did not indicate that resident #001 had received an assessment or had a physiotherapy exercise program in place for the medical condition observed by the Inspector.

During an interview with Inspector #625, the RPN LTC Team Lead #101 stated that they had observed resident #001 to have the medical condition observed by the Inspector for a specific period of time, and that the resident could benefit from receiving physiotherapy for the condition. The Team Lead also stated that a referral for physiotherapy services was required for physiotherapy to assess and work with the resident on the medical condition but that one had not been completed.

During an interview with Inspector #625, PT Assistant #114 stated that resident #001 had a medical condition which had worsened over months. The PT Assistant stated that the medical condition had not been addressed in the most recent physiotherapy assessment that occurred on a specific date in the spring of 2016, as it had not been a concern at that time. They also stated that the resident had not been assessed by a Physiotherapist since the assessment on the specific date in the spring of 2016, and there was no physiotherapy plan in place for the resident's observed medical condition. [s. 26. (3) 7.]

WN #11: 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 has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act: where under the program, staff used any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids were appropriate for the resident based on the resident's condition.

Inspector #625 observed resident #001 with a medical condition on four specific dates. During two of the observations, the Inspector noted an object not manufactured to address or treat the resident's medical condition in use by the resident to address the medical condition.

During an interview with Inspector #625, the RPN LTC Team Lead #101 stated that resident #001 had a medical condition and that they had identified it over a specific period of time.

During an interview with Inspector #625, RPN #107 stated that staff had used the object to address resident #001's medical condition.

During an interview with the PT Assistant #114, they stated to the Inspector that they had noticed resident #001's medical condition several months prior and that the resident could benefit from the use of a specific medical device to address the medical condition. The PT Assistant stated the use of the medical device required a referral to an Occupational Therapist, and that nursing agreed that the resident would benefit from the device. The PT Assistant stated that they had observed the medical condition progressing over several months and that the resident could have benefited from a referral to an Occupational Therapist earlier. [s. 30. (1) 2.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

The Long-Term Care Homes Act, 2007 s. 79 (3) (g.1) identifies that the required information for the purposes of subsections (1) and (2) includes a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004, entered into between the licensee and a local health integration network.

Inspector #625 reviewed the LTCH Licensee Confirmation Checklist Admission Process completed by the Administrator/DONPC of the home. The home had responded that they did not have a copy of the home's service accountability agreement posted in the home in a conspicuous and easily accessible location.

The Inspector toured the long term care unit and was not able to locate a posted copy of the home’s service accountability agreement.

During an interview with RPN #113, they stated that they had not seen a copy of the home’s service accountability agreement posted in the home. They stated that if it was posted, it would be located in one of two locations where resident information was posted on the long-term care unit, on a bulletin board inside of the dining room or on a bulletin board in the hallway outside of the dining room. The RPN checked the board located inside of the dining room and confirmed the agreement was not posted in that location.

During an interview with RPN #109, they stated that they had not seen a copy of the home’s service accountability agreement posted in the home and that it would be posted on bulletin boards where other resident information was posted on the long-term care unit. The RPN checked the two locations and confirmed the agreement was not posted in either location.

During an interview with the Administrator/DONPC, they acknowledged that the home's service accountability agreement was not posted in the home. [s. 79. (1)]

Issued on this 9th day of January, 2018

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) :	KATHERINE BARCA (625), DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2017_703625_0015
Log No. / No de registre :	019363-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 3, 2018
Licensee / Titulaire de permis :	LADY DUNN HEALTH CENTRE 17 Government Road, Box 179, Wawa, ON, P0S-1K0
LTC Home / Foyer de SLD :	LADY DUNN HEALTH CENTRE 17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kadean Ogilvie-Pinter

To LADY DUNN HEALTH CENTRE, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_669642_0011, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The licensee shall specifically:
(a) Review the plans of care for resident #004 and for all residents in the home using bed side rails to ensure that the plans provide clear direction in regards to the use of bed side rails. The review should encompass all documents in the residents' health care records that compose their plans of care including, but not limited to, care plans, physician's orders, assessments and Kardexes;
(b) Review the plan of care for resident #009 and for all residents in the home with interventions, including a particular nutrition related intervention, to ensure that the plans provide clear direction in regards to the particular intervention. The review should encompass all documents in the residents' health care records and any unit tools, lists, documents, etc. the home uses with respect to the intervention;
(c) Review the plans of care for residents #006, #009 and for all residents in the home receiving a second particular nutrition related intervention, to ensure that the plans provide clear direction in regards to the intervention. The review should encompass all documents in the residents' health care records and any unit tools, lists, documents, etc. the home uses with respect to the intervention;
(d) Review the plans of care for each resident in the home to ensure that all components of the plan of care are accurate, current and consistent and provide clear directions to staff and others who provide direct care to the residents; and
(e) Maintain documentation of the changes made to the plans of care including, but not limited to, the date of each review, the name and classification of the staff that completed each review, any discrepancies/inconsistencies/deficiencies identified and any changes made to ensure the plans provided clear directions.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During inspection #2017_669642_0011 Compliance Order #001 was issued pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s. 6. (1) (c). The licensee was ordered to ensure that a resident #007's plan of care set out clear directions to staff and others who provided direct care to the resident, specifically with regards to the resident's use of bed side rails, with a compliance

date of September 15, 2017.

During a review of the home's discharged resident report, resident #007 was identified as no longer residing in the home as of July 15, 2017. However, additional non-compliance, including non-compliance regarding bed side rail use, was identified during this inspection pursuant to s. 6. (1) (c).

Resident #009 was identified as having had a nutrition related concern according to the 90 day Resident Assessment Instrument - Minimum Data Set (RAI-MDS) relative to the admission assessment.

(a) Inspector #577 conducted a record review of resident #009's weight history and found a significant weight change between two months in 2017.

During a record review of the RD's orders, Inspector #577 identified an order for a particular nutrition intervention at a specific frequency. A second order dated two weeks after the previous order, identified that the intervention was to be completed at a different specific frequency.

A record review of resident #009's current care plan identified that the nutrition intervention was to be completed at both of the specified frequencies as per the dietitian.

A further review of resident #009's health care record identified that the particular nutrition intervention at a specific frequency had not been completed as ordered over 14 consecutive dates in the spring and summer of 2017.

Inspector #577 interviewed the RPN LTC Team Lead #101 who reported that the nutrition related intervention for resident #009 was not completed at a specific frequency in one month of 2017, and the nutrition related intervention in the resident's care plan was unclear.

(b) During a record review of the RD's order, Inspector #577 identified orders for a nutrition related intervention at two specific frequencies. The orders were dated three different specific dates in the spring and summer of 2017.

A record review of resident #009's care plan in place at time of their admission identified the resident was to have the nutrition related intervention at a specific frequency as per the RD's recommendation.

A further record review of resident #009's updated care plan interventions identified the intervention was to be provided to the resident at a different specific frequency.

Inspector #577 conducted a review of resident #009's Medication Administration Records (MARs) and found that the nutrition related intervention was not listed for two consecutive months in the spring of 2017. The Inspector found that the intervention at a specific frequency was initiated on the MARs on a particular date in the spring of 2017 and changed to a different frequency six days later.

Inspector #577 reviewed the home's policy titled "Oral Nutrition Supplements", last revised December 2016, which indicated:
- an order for a specific nutrition supplement was to be written on the Physician's Order form by the RD and the order was to be processed by nursing who would transcribe the order to the MARs. The order was to specify the volume and frequency of the chosen supplement; and
- the RD was to complete a progress note and the LTC Lead would update the resident's care plan about the order for the nutritional supplement.

Inspector #577 spoke with RPN #103 who reported that the particular nutrition related intervention was not initiated for resident #009 until a specific month in the spring of 2017.

Inspector #577 spoke with the RPN LTC Team Lead #101 who reported that the nutrition related intervention was not listed on resident #009's MARs for two consecutive months in 2017, and should have been. They confirmed that the plan of care was unclear with respect to the provision the intervention to resident #009. (625)

2. Inspector #625 observed bed side rails raised on resident #004's bed functioning as potential restraints.

Inspector #625 reviewed resident #004's health care record including:
- the current Long Term Kardex/ALC (undated) that identified the resident used "siderails";
- the current Consent to Use of Restraint(s) that identified the resident used "side rails x 4 for bed";
- the current CCRS MDS Kardex Report, that identified the resident used "full

bed rails";
- the Restraint Assessment/Physician Order and Individual Restraint Re-Assessment Form, both dated a particular date in the summer of 2017, that identified the resident used "siderails x 4";
- the Bed System Entrapment Risk Assessment dated a particular date in the winter of 2017, that indicated the resident used full, horizontal left and right bed rails. The assessment contained undated hand written entries "[change] to Quarter Rails" and "Quarter rails in place" and one hand written entry "Reviewed. No changes made"; and
- the current care plan that identified the resident used "4 side rails when is [sic] bed" and "uses bed rails".

During a phone interview with Inspector #625, the RPN LTC Team Lead #101 acknowledged that resident #004's plan of care identified different bed side rails in use as "side rails", "full bed rails", "4 side rails", "side rails x 4", "uses bed rails", full left and right rails and quarter rails. The Team Lead acknowledged that resident #004's plan of care required revision to provide clear direction to staff, as it contained references to different types of bed side rails in use. (625)

3. During an interview with Inspector #625 on a date in the fall of 2017, RPN #103 identified that resident #006 did not have a particular intervention in place to address a specific concern.

Inspector #625 reviewed resident #006's health care record and identified:
- The current care plan indicated that staff were to provide the resident with a particular intervention related to nutrition care;
- The current LTC Diets list indicated the resident was to receive the particular intervention related to nutrition care;
- A Long Term Care Fluid Intake sheet dated specific dates in the fall of 2017, listed the resident was to receive the particular intervention related to nutrition care in one area of the sheet and a different intervention in another area of the sheet; and
- A Long Term Care Fluid Intake sheet dated different specific dates in the fall of 2017, did not list the particular intervention related to nutrition care on the sheet but listed a different intervention on another area of the sheet.

During interviews with RPNs #103 and #104, they acknowledged that the Long Term Care Fluid Intake sheets dated specific dates in the fall of 2017, contained details related to the particular intervention related to nutrition care and that the

direction regarding the intervention was not clear on the documents.

During an interview, Registered Dietitian (RD) #105 acknowledged that the plan of care, specifically the Long Term Care Fluid Intake sheets for specific dates in the fall of 2017, were not consistent in identifying the nutrition intervention in place.

During an interview with Inspector #625, the RPN Long-Term Care (LTC) Team Lead #101 acknowledged that Long Term Care Fluid Intake sheets for specific dates in the fall of 2017, did not provide clear direction with respect to the nutrition intervention in place.

The decision to issue this compliance order (CO) was based on the scope which identified a pattern of occurrence, the severity which indicated the potential for harm, and the compliance history which, despite previous non-compliance issued, non-compliance continued with this area of the legislation. The compliance history specific to this legislation includes the previous issue of four consecutive compliance orders as follows:
- CO #001 issued on September 6, 2017, during Follow-Up inspection #2017_669642_0011;
- CO #002 issued on December 21, 2016, during Resident Quality Inspection #2016_283542_0005;
- CO #005 issued on December 22, 2015, during Resident Quality Inspection #2015_332575_0020; and
- CO #001 issued on October 6, 2015, during Complaint inspection #2015_376594_0015. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 18, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plans of care is provided to residents as specified in the plans.

The licensee is specifically ordered to:
(a) Ensure that all nursing staff review resident #011's plan of care and provide care to the resident as specified in their plan, with a focus on personal care;
(b) Ensure that all nursing staff review resident #010's plan of care and provide care to the resident as specified in their plan, with a focus on a particular intervention;
(c) Develop and implement a system that ensures that all nursing staff are aware of the contents of the residents' plans of care and provide care to the residents as specified in their plans;
(d) Maintain records of the development and implementation of the system including, but not limited to, date(s) of implementation, the names and classifications of staff trained/engaged/involved in the system, auditing records, etc.

Grounds / Motifs :

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

Inspector #625 observed that resident #011 required specific grooming. Inspector #577 also observed the resident to require specific grooming on two additional dates.

Inspector #577 reviewed resident #011's care plan which indicated the resident required staff to perform the required grooming.

During an interview with Inspector #577, RPN #108 reported that resident #011 performed the grooming activity with staff assistance.

Inspector #577 spoke with RPN #113 and RPN #109 who both reported that resident #011 completed the particular grooming activity themself. RPN #109 reviewed resident #011's care plan and the RPN acknowledged that the care plan identified that the resident required assistance by staff with the grooming activity. (577)

2. Resident #010 was observed by Inspector #577 to have a specific medical condition.

Inspector #577 reviewed resident #010's care plan which indicated that the resident had a specific medical condition and required a particular intervention that staff were to document on the flow sheet daily.

A review of resident #010's Seven Day Observation and Monitoring forms for two consecutive months in 2017, identified that:
- in one month, the intervention was not documented as being done on 64 per cent of the days; and
- in the second month, the intervention was not documented as being done on 36 per cent of the days.

During an interview with Inspector #577, PSW #106 reported that they had not performed the intervention with resident #010 that day.

During an interview with Inspector #577, RPN #107 reported that the resident's involvement in a particular activity of daily living (ADL) was the intervention.

Inspector #577 spoke with RPN LTC Team Lead #101 who reported that nursing staff were required to perform the intervention as per the care plan. They further confirmed that performing the intervention required staff to complete specific activities.

The decision to issue this compliance order (CO) was based on the severity which indicated the potential for harm, and, although the scope was isolated, the home's compliance history which, despite previous non-compliance issued, continues to demonstrate non-compliance with this area of the legislation. The

compliance history specific to this legislation includes:
- A Voluntary Plan of Correction (VPC) issued on December 21, 2016, during Resident Quality Inspection #2016_283542_0005; and
- A VPC issued on December 22, 2015, during Resident Quality Inspection #2015_332575_0020. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 18, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 3rd day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Katherine Barca

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