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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2017	2017_561583_0006	005288-17	Resident Quality Inspection

Licensee/Titulaire de permis

MISSISSAUGA LONG TERM CARE FACILITY INC.
26 PETER STREET NORTH MISSISSAUGA ON L5H 2G7

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

MISSISSAUGA LONG TERM CARE FACILITY
26 PETER STREET NORTH MISSISSAUGA ON L5H 2G7

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

KELLY HAYES (583), CYNTHIA DITOMASSO (528), NATASHA JONES (591)

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 8, 9, 10, 13, 15, 16, 20 and 21, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection (RQI):
Follow Up Inspection log #034135-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Food Service Supervisor (FSS), Registered staff including Registered Nurses (RNs), and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, residents and family members. During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, and reviewed relevant policies, procedures and practices.

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

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

12 WN(s)
9 VPC(s)
3 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. 6. (7)	CO #002	2016_210169_0014	583

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where bed rails were used, the resident was assessed, his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident where bed rails are used, or that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), where recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails.

i. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep).

ii. The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident.

iii. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary.

iv. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device).

v. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident. (528)

B) Throughout the course of the inspection, resident #036 was observed laying in bed on an identified mattress, identified rails were in place and the resident was sleeping sideways so their pillow and head was resting on the bed rail, the mattress was quite soft.

i. A Mississauga Long Term Care PASD Assessment, on an identified date in 2017, did not include all an assessment of all factors as outlined in prevailing practices, including but not limited to, a formalized sleep assessment, safe use of the rails, timelines when trialed without the bed rails, and other medical or physical risk factors. Interview with the DOC confirmed that an individualized bed rail assessment did not include all aspects of prevailing practice requirements.

ii. Furthermore, in May 2016, resident #036's bed indicated that the resident's bed system passed zones one to four of entrapment for an identified mattress. Interview with RPN #101 confirmed that the resident's bed system had changed, when the identified mattress was applied, approximately one month ago. Interview with the DOC and the contracted service provider who completed the last entrapment audit confirmed that the bed system was not retested for entrapment when the bed system changed. Interview with the maintenance staff confirmed that the bed did not have a hard perimeter or any other accessories to minimize potential zones of entrapment. (528)

C) During the course of the inspection, resident #043 was observed in bed with two

identified rails in identified positions. Review of the plan of care identified that the resident required both rails but did not include a formalized bed rail assessment that considered all of the factors required for safe bed rail use, as outlined prevailing practices, including but not limited to, a formalized sleep assessment, safe use of the rails, timelines when trialed without the bed rails, and other medical or physical risk factors. Interview with the DOC confirmed that a formalized bed rail and sleep assessment had not been completed to assess the resident when using the bed rails. (591)

D) On March 16, 2016, resident #063 was observed laying in bed with two rails in identified positions. A review of the written plan of care indicated that the resident required two identified rails for identified reasons; however, did not include a formalized bed rail assessment considering all factors contributing to safe bed rail use. Furthermore, review a document titled "Facility entrapment Inspection sheet", on an identified date in 2016 indicated resident #063's bed had two identified rails, an identified mattress, and passed zones six and seven, however; did not indicate whether or not the bed passed or failed zones one to four. Interview with RPN #101 confirmed there was no formalized bed rail assessment completed for the resident. Interview with the DOC confirmed that zones of entrapment had not tested on any bed since an identified date in 2016, and therefore, resident #063's bed was not tested for entrapment of zones one to four. (528)

E) Review of the home's policy "Minimizing of Restraining: Use of Side Rails", last reviewed March 2015, did not guide staff to complete an individual bed rail assessment considering all factors for safe bed rail use, as defined in prevailing practices Clinical Guidance document. (528)

F) Interview with the DOC confirmed that formalized sleep observations were not completed on residents to determine their patterns or habits and the home did not have a formalized individual bed rail assessment for the resident that included the trial alternatives. The DOC reported that the specified rails were assessed using the home's Safety Restraint Assessment form, all other bed rails were assessed using the homes PASD Assessment, and the home did not have a separate formalized bed rail assessment. The DOC also confirmed that entrapment in the home had not been completed since external contracting service completed an entrapment audit in May 2016 , and any bed system changes since then had not been tested, as staff in the home were not trained to assess for zones of entrapment and the external contractor had not returned. (528) [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each program, in addition to meeting the requirements set out in section 30, provided for assessment and reassessment instruments.

The home's Falls Prevention and Management Program, version 1.3, updated February 2016 was reviewed and did not provide for assessment and reassessment instruments when a resident had a fall, as required in Ontario Regulations 79/10 s. 49(2)

Specifically, post fall management directed staff to complete the following:

1. Initiate a head injury routine if indicated by an un-witnessed fall or a witnessed fall where the resident had hit their head, and assess the resident's level of consciousness and any potential injury associated with the fall.
2. Notify the attending physician and ensure immediate treatment after the fall. Also alter the Physician if the resident is taking any anticoagulants.
3. Complete incident report and detailed progress note.
4. Investigate the contributing factors associated with the fall including location, time and related activity.
5. Review fall prevention interventions and modify plan of care as indicated.
6. Communicate to all shift that resident has fallen and is at risk to fall.
7. Intitiate 72-hour monitoring record and updated resident status with progress note on each shift.
8. Refer to physiotherapist for follow-up.

However, the staff were not directed to use assessment or reassessment instruments specifically designed for falls. During the inspection it was identified residents #015, #028, #063 were not assessed post fall where the condition or circumstances of the residents required, using a clinically appropriate assessment instrument that was specifically designed for falls. Interview with the DOC confirmed that home's policy directed staff to document the resident's post fall assessment in a progress note did not include an assessment or reassessment instrument (528) [s. 48. (2) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A. On two identified dates in 2016 and 2017, the MDS (Minimum Data Set) assessment identified that resident #030 required specific interventions with eating; however, review of the point of care documentation for the assessment review dates, documented that the resident required a different intervention with eating. Interview with PSW #118 and PSW #117 they confirmed the specific interventions the resident required in 2016 and 2017. In an interview with the RAI Coordinator it was confirmed that the MDS Assessment and PSW documented care of resident #030 were not consistent with each other, related to interventions with eating. (528) [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident was given an opportunity to participate fully in the development and implementation of their care plan.

In an interview with resident #033 and #036 in March 2017, it was shared that they had specific preferences related to eating and nutrition hydration requirements. It was confirmed that these preferences had been communicated to the home but had not been permitted.

During a lunch dining observations in March 2017, it was identified that resident #033's and resident #036's specified preferences were beneficial to the resident's nutrition and hydration status and well being.

In an interview with the DOC on March 20, 2017, it was confirmed that resident #033 and #036 were not provided an opportunity to participate fully in the development and implementation of their eating care plan. (583) [s. 6. (5)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care is reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Review of the plan of care for resident #030 identified that the resident required an intervention with eating. Review of point of care documentation was completed and the level of assistance the resident required was reviewed. Interview with PSW staff #119 confirmed what intervention was required at meals. Interview with RPN staff #101 confirmed the written plan of care was not updated to include the intervention the resident required with eating when the care need changed.

B) In March 2017, PSW staff #118 was observed providing one person physical assistance for resident #015 during a specified activity. In 2016 and 2017, the MDS

assessments for resident #015 identified that the resident required a specified level of assistance with this activity. However, review of the written plan of care directed that the resident required a different level of assistance. Interview with RPN #101 confirmed that the plan of care was not updated to identify the resident's required assistance with the activity.

C. The plan of care identified that resident #015 was at risk for falls with a history of falls and that they required specific interventions. During two months in 2017, the resident had four falls, three of which were from the same location.

i. Review of the plan of care did not include any additional fall prevention interventions related to the resident falling from a repeat location. Interview with RPN #101 confirmed that no additional interventions had been put in place to keep the resident from falling from this location, after the increase in resident's falling.

ii. RPN staff #101 also confirmed that the home had a "Falling Leaves Program" in which residents who had fallen in the last three months were placed on the list to alert staff of their high risk for falls. A leaf was to be placed on the resident's bed and mobility device. RPN staff #101 confirmed that during the course of the inspection resident #015 was not included on the "Falling Leaves Program" and therefore not identified them as a frequent faller. Interview with the DOC confirmed that the home had monthly meeting, at which time, they would discuss the residents who had fallen but a meeting had not been held since an identified date in 2017, prior to resident #015's increased falls.

Resident #015 was not reassessed and the care plan was not revised to include any additional falls prevention interventions when the resident had increased falls in two identified months in 2017. [s. 6. (10) (b)]

4. The licensee failed to ensure that different approaches were considered in the revision of the plan of care when the plan of care was being revised because the care set out in the plan had not been effective.

An observation in 2017, revealed resident #017 had a dressing on an identified area. In an interview on the same day, the resident confirmed they had an alteration of skin integrity on the area.

A review of resident #017's clinical health record indicated they had an alteration of skin integrity on an identified area. Documentation on an identified date confirmed the

alteration of skin required specific treatments and had worsened.

A review of a document in the home's Skin and Wound Care program binder titled "Team Members Roles and Responsibilities" indicated the DOC or skin care coordinator should make a referral to an Enterostomal (ET) Nurse for specified types of altered skin integrity or when there are difficulties in healing. A review of a document from the program titled "Pathway to Assessment/Treatment of Skin Tears" indicated that for specified types of altered skin integrity, a referral should be made to an ET or wound and skin specialist; consult Physician and ET therapist for review of treatment plan for identified parameters.

In interviews in 2017, PSW staff #117 and RPN staff #113 stated resident #017 had an alteration of their skin integrity for several weeks which was being treated. The PSW stated the home had tried several specified interventions, however; the resident refused them. RN staff #108 further stated the home tried additional interventions but they not effective for identified reasons.

In an interview in 2017, RPN #101 confirmed the alteration in skin integrity was not healing. When questioned by an LTCH Inspector as to why the resident was not referred to an ET nurse or Wound Specialist, they stated they had planned to notify the DOC to make a referral.

In an interview in 2017, the DOC confirmed staff had not followed the Skin and Wound program procedure for caring for resident #017's skin integrity, and a referral to an ET Nurse or Wound Specialist had not been made but should have been.

The home did not ensure that when the care set out in the plan of care had not been effective in the treatment of resident #017's skin integrity, different approaches had been considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the resident is given an opportunity to participate fully in the development and implementation of their care plan; to ensure the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An observation in March 2017, at a specified time on the first floor of the home revealed the screen on a medication cart had resident personal health information (PHI) visible which included resident names, medication prescriptions, medical diagnosis and health card number. The registered staff was conducting their medication pass and they were not in the vicinity of the medication cart. Several residents passed by the cart, which was parked in the corridor beside the dining room. In an interview with RPN staff #113 they confirmed the screen was left open on the medication cart, revealing resident PHI.

The home did not ensure the residents' rights were fully respected and promoted in keeping their PHI confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is treated with courtesy and respect and in a way that recognizes their individuality and respects the resident's dignity and that personal health information within the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with the Act., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Observations on in March 2017 at an identified time revealed there were two RPNs on duty, however; there was no RN on duty. The DOC was on vacation out of the country, and not available.

A review of the home's staffing schedule for March 2017 indicated, there was no RN scheduled for the 0700 hours to 1500 hours on an identified date in March 2017, and also that RN staff #108 was scheduled to work that evening. A review of the home's policy titled "Staffing plan", reviewed January 2016, indicated a RN must be present in the building at all times.

In an interview on the same day, RPN staff #101 confirmed there was no RN in the home. They indicated RN staff #108, was scheduled as the RN on call for the day, but could be available to come to the home if needed. They further stated, RN staff #108 was scheduled and would be working that evening from 3 – 11pm.

At 1:45 pm, RN staff #108 was observed to be in the home. In an interview with the Administrator on an identified date in March 2017, it was confirmed that there was no RN in the building for the for the morning of an identified date in March 2017. In an interview in March 2017, the DOC confirmed an RN had not been scheduled to work on the identified date in March 2017 but should have been.

The home failed to ensure a registered nurse was on duty and present in the home at all times. [s. 8. (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 at least one registered nurse who is a both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations and to ensure during the hours the Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

During the course of the inspection, it was identified that the home's Falls Prevention and Management Program policies did not direct staff to use a post-fall assessment instrument that was specifically designed for falls.

i. Ontario Regulations 79/10 s. 49(2) required 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.

ii. Interview with RPN #101 and DOC confirmed that home's policy directed staff to document the resident's post fall assessment in a progress note did not include a clinically appropriate post fall assessment tool. [s. 8. (1) (a)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Per regulation 136(2)2, the drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Observation on an identified date in March 2017, of the medication cart on the first floor during the medication cart inspection revealed several cards of discontinued controlled medications for several residents, dating back to March 10, 2017, were stored in the cart.

A review of the home's policy #5.8.1, titled "Medication Disposal – Controlled Substances/LTCH's", revised July 2014 indicated:

i) all controlled substances to be destroyed should always be stored in a designated area separate from any controlled substance available for administration to a resident, and
ii) for all controlled substances to be destroyed, the resident's individual count sheet is affixed to the controlled substance for destruction which in the presence of both registered personnel is witnessed being placed in the double-locked location designated for controlled substances waiting awaiting disposal.

In interviews on in March 2017, RPN staff #101, RN staff #108 and RPN staff #113 stated non-narcotic medications for destruction were placed in the sharps bin on the medication cart, with the reason for destruction documented in the resident's electronic

medication administration record (EMAR). They further stated if a controlled substance had been removed from the package and was for destruction, it was signed for by two registered staff and placed in the sharps container. For discontinued controlled substances still in their package, they are signed for by two registered staff, wrapped with the sheet they had signed on and stored in the same locked narcotic bin in the locked medication cart as the controlled medications to be administered to the residents until they could be given to the DOC for destruction.

In an interview on March 20, 2017, with the DOC, they confirmed that controlled substances were stored in the narcotic bin in the medication cart, wrapped with their count sheet with the controlled substances for administration to the residents. Medications and controlled substances still in their packages were stored in the medication cart until they were brought down to be disposed of in a pail in the locked medication room in the basement. Medications and controlled substances not in their packages were disposed of in the sharps container on the medication cart.

The licensee failed to ensure the home's medication policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the licensee is required to ensure that the policy is in compliance with and is implemented in accordance with all applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

An interview was completed with resident #033 on an identified date in 2017. Resident #033 shared that on an identified date in 2017, an identified staff member made specified remarks when a question was asked. The resident shared they felt they were not treated with dignity or respect.

The Regulations define "verbal abuse", as any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A review of resident #033's communication care plan identified the resident required specified approaches.

In an interview with the identified staff member they confirmed the remarks that were made to the resident. In an interview with the DOC on March 20, 2017, it was confirmed that staff #108's verbal remarks towards resident #033 were inappropriate. [s. 19. (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 the licensee protects all residents from abuse by anyone, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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) Resident #015 had four falls in two months in 2017. Review of the plan of care identified that registered staff documented specified assessments post fall but did not include an assessment of the resident using a clinically appropriate assessment tool specifically designed for falls. Interview with RPN staff #101 confirmed that the resident had multiple falls and registered nursing staff documented assessments in a progress note. (528)

B) A review of clinical health record for resident #028 indicated they sustained a witnessed fall from a specified area in 2017. The resident sustained minor injuries. At the time of the fall, the resident refused to allow the staff to conduct specified assessments, however; one identified assessment was completed. Review of the plan of care did not include a clinically appropriate assessment instrument specifically designed for falls was not completed for, confirmed by the Director of Care (DOC) (528)

C) A review of the clinical health record for resident #063 indicated they sustained 3 falls over a 3 month time period in 2016, and one fall in 2017. Assessments conducted by registered staff after each of the above mentioned falls included specified routine assessments.

A clinically appropriate assessment instrument designed specifically for falls was not completed for the resident on clinical health record review, and a review of the home's Falls program did not include a clinically appropriate assessment instrument to be completed for residents that sustained falls as required by the Long Term Care Homes Act and regulations. This was confirmed by the Director of Care (DOC) in an interview with LTCH Inspector #528.

The home failed to ensure a clinically appropriate assessment instrument specifically designed for falls was used for resident #063 post falls. [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 #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program policies and procedures related to hydration were implemented, in consultation with a registered dietitian.

A review of resident #030's plan of care identified that the had a specified decline in their nutritional status an identified time in 2017.

The home's "Nutrition Care and Hydration Program and Hot Weather Related Illness Prevention and Management Program", version 2.2, updated February 1, 2016, was reviewed. The dehydration reporting and documenting process directed registered staff to complete an electronic report daily that identified any resident that consumed less than 3000 milliliters (ml) of fluids over the previous three day period. The report was to be filed in the dehydration tracking binder. Staff were to then complete a referral to the RD and attach a completed dehydration risk appraisal.

The dietary report showed that resident #030 had a total fluid intake of less than 3000 ml on an identified consecutive days in 2017. The resident was admitted to the hospital after this time period 2017 with a diagnosis related to low fluid intake.

A review of the dehydration tracking binder showed that the dehydration tracking report was not completed for any residents in the home on 4 identified dates in 2017. In an interview with the RD in March 2017, it was confirmed that the RD did not receive any referrals for low fluid intake with an attached dehydration risk appraisal on specified dates in 2017, for resident #030. It was confirmed that the home's hydration policy and procedures were not implemented in consultation with the RD. [s. 68. (2) (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 the nutrition care and hydration program policies and procedures related to hydration are implemented, in consultation with a registered dietitian., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

An observation in 2017, revealed a medicine cup was at resident #020's bedside with several medications in it while the resident was sleeping. A review of the resident's MAR and a review of the last medication reconciliation review did not include an order from the physician for self-administration.

In interviews in March 2017, RPN staff #101 and RPN staff #113 confirmed the resident self-administered their medication and had been permitted to self-administer their medications without a physician's order.

In an interview in 2017, the DOC confirmed an order was not obtained for resident #020 to self-administer their medication. [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident administers a drug to himself or herself unless the administration has been approved by they prescriber in consultation with the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that on every shift symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action was taken as required.

On an identified date in 2016, resident #043 began displaying symptoms of an identified type of infection. Several days later, the resident was ordered an identified prescription. Review of the plan of care did not include that the resident was monitored and symptoms were recorded every shift. Interview with the DOC confirmed that registered staff were not documenting an assessment of the residents symptoms every shift, from when the resident first began displaying symptoms of infection, as required. [s. 229. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.

At the beginning of this Resident Quality Inspection, the Long Term Care Home (LTCH) Inspectors were informed by the home's Administrator that the DOC would be on vacation from March 10 to 17 and returning on March 20, 2017. The FSS, who was not an RN was assigned to cover in her absence. They confirmed the home had 55 beds.

A review of the home's schedule for March 2017, indicated the DOC was on vacation for a 10 day time period as mentioned above. No replacement for the DOC in her absence was indicated, and the home had only one registered staff on duty per shift working in the capacity of a RN. In addition it was confirmed that there was no RN in the building for the morning of an identified date in March 2017.

In an interview on March 19, 2017, the DOC confirmed they were on vacation for March 10 and March 13 to 17, 2017 and they were not available as they had been out of the country. It was confirmed during their absence, that there was no DOC coverage in the home and the home's staffing plan did not include DOC coverage of 24 hours per week in their absence as required by the legislation.

The home has failed to ensure a DOC was on site at the home at least 24 hours per week from March 13 to 17, 2017. [s. 213. (1)]

Issued on this 1st 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) :	KELLY HAYES (583), CYNTHIA DITOMASSO (528), NATASHA JONES (591)
Inspection No. / No de l'inspection :	2017_561583_0006
Log No. / Registre no:	005288-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 24, 2017
Licensee / Titulaire de permis :	MISSISSAUGA LONG TERM CARE FACILITY INC. 26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7
LTC Home / Foyer de SLD :	MISSISSAUGA LONG TERM CARE FACILITY 26 PETER STREET NORTH, MISSISSAUGA, ON, L5H-2G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Novak Bajin

To MISSISSAUGA LONG TERM CARE FACILITY INC., 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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop an assessment tool related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document ??Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006.

2. Re-evaluate all of the bed systems in the home in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006"and document the results. At a minimum, documentation shall include type of mattress and unique mattress identifier, bed rail type, bed frame serial number, date evaluated, name of evaluator, zones tested, issues identified and follow up action taken if necessary.

3. An interdisciplinary team shall assess all residents who use one or more bed rails using the bed safety assessments tool and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents who require bed rails which have been identified after re-assessing each resident using the bed safety assessment tool. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

5. Educate the registered nursing staff on the bed rail assessment tool and the homes requirements for bed safety assessment.

Grounds / Motifs :

1. 1. The licensee failed to ensure where bed rails were used, the resident was assessed, his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident
where bed rails are used, or that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Prevailing practices were identified in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), where recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails.

i. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep).

ii. The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident.

iii. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary.

iv. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device).

v. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident. (528)

B) Throughout the course of the inspection, resident #036 was observed laying in bed on an identified mattress, identified rails were in place and the resident was sleeping sideways so their pillow and head was resting on the bed rail, the

mattress was quite soft.

i. A Mississauga Long Term Care PASD Assessment, on an identified date in 2017, did not include all an assessment of all factors as outlined in prevailing practices, including but not limited to, a formalized sleep assessment, safe use of the rails, timelines when trialed without the bed rails, and other medical or physical risk factors. Interview with the DOC confirmed that an individualized bed rail assessment did not include all aspects of prevailing practice requirements.

ii. Furthermore, in May 2016, resident #036's bed indicated that the resident's bed system passed zones one to four of entrapment for an identified mattress. Interview with RPN #101 confirmed that the resident's bed system had changed, when the identified mattress was applied, approximately one month ago. Interview with the DOC and the contracted service provider who completed the last entrapment audit confirmed that the bed system was not retested for entrapment when the bed system changed. Interview with the maintenance staff confirmed that the bed did not have a hard perimeter or any other accessories to minimize potential zones of entrapment. (528)

C) During the course of the inspection, resident #043 was observed in bed with two identified rails in identified positions. Review of the plan of care identified that the resident required both rails to assist with bed mobility but did not include a formalized bed rail assessment that considered all of the factors required for safe bed rail use, as outlined prevailing practices, including but not limited to, a formalized sleep assessment, safe use of the rails, timelines when trialed without the bed rails, and other medical or physical risk factors. Interview with the DOC confirmed that a formalized bed rail and sleep assessment had not been completed to assess the resident when using the bed rails. (591)

D) On March 16, 2016, resident #063 was observed laying in bed with two rails in identified positions. A review of the written plan of care indicated that the resident required two identified rails for identified reasons; however, did not include a formalized bed rail assessment considering all factors contributing to safe bed rail use. Furthermore, review a document titled "Facility entrapment Inspection sheet", dated May 2, 2016 indicated resident #063's bed had two assist rails, a regular foam mattress, and passed zones six and seven, however; did not indicate whether or not the bed passed or failed zones one to four. Interview with RPN #101 confirmed there was no formalized bed rail assessment

completed for the resident. Interview with the DOC confirmed that zones of entrapment had not tested on any bed since May 2016, and therefore, resident #063's bed was not tested for entrapment of zones one to four. (528)

E) Review of the home's policy "Minimizing of Restraining: Use of Side Rails", last reviewed March 2015, did not guide staff to complete an individual bed rail assessment considering all factors for safe bed rail use, as defined in prevailing practices Clinical Guidance document. (528)

F) Interview with the DOC confirmed that formalized sleep observations were not completed on residents to determine their patterns or habits and the home did not have a formalized individual bed rail assessment for the resident that included the trial alternatives. The DOC reported that "full bed rails" are assessed using the home's Safety Restraint Assessment form, all other bed rails were assessed using the homes PASD Assessment, and the home did not have a separate formalized bed rail assessment. The DOC also confirmed that entrapment in the home had not been completed since external contracting service completed an entrapment audit in May 2016, and any bed system changes since then had not been tested, as staff in the home were not trained to assess for zones of entrapment and the external contractor had not returned. (528) [s. 15. (1) (a)] (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Order / Ordre :

The licensee shall ensure the following:

1) Develop a clinically appropriate post fall assessment instrument.

2) Review and revise the Falls Management Program, to include, a clinically appropriate assessment instrument for registered staff to use when assessing and reassessing a resident after they had fallen.

3) Educate all registered staff on the revised Falls Management Program, included but not limited to, the newly developed clinically appropriate assessment instrument and any other post fall management monitoring required.

4) Monitor to ensure the Falls Management Program is being followed and that residents are being assessed post fall using a clinically appropriate assessment instrument when required.

Grounds / Motifs :

1. 1. The licensee failed to ensure that each program, in addition to meeting the requirements set out in section 30, provided for assessment and reassessment instruments.

The home's Falls Prevention and Management Program, version 1.3, updated February 2016 was reviewed and did not provide for assessment and reassessment instruments when a resident had a fall, as required in Ontario Regulations 79/10 s. 49(2)

Specifically, post fall management directed staff to complete the following:

1. Initiate a head injury routine if indicated by an un-witnessed fall or a witnessed fall where the resident had hit their head, and assess the resident's level of consciousness and any potential injury associated with the fall.
2. Notify the attending physician and ensure immediate treatment after the fall. Also alter the Physician if the resident is taking any anticoagulants.
3. Complete incident report and detailed progress note.
4. Investigate the contributing factors associated with the fall including location, time and related activity.
5. Review fall prevention interventions and modify plan of care as indicated.
6. Communicate to all shift that resident has fallen and is at risk to fall.
7. Intitiate 72-hour monitoring record and updated resident status with progress note on each shift.
8. Refer to physiotherapist for follow-up.

However, the staff were not directed to use assessment or reassessment instruments specifically designed for falls. During the inspection it was identified residents #015, #028, #063 were not assessed post fall where the condition or circumstances of the residents required, using a clinically appropriate assessment instrument that was specifically designed for falls. Interview with the DOC confirmed that home's policy directed staff to document the resident's post fall assessment in a progress note did not include an assessment or reassessment instrument (528) [s. 48. (2) (b)] (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

Order # / Ordre no : 003

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall complete the following:

1. Ensure that when care set out in the plan of care is not effective in relation to wound management that different approaches are considered.

2. Refer resident #017 to an ET Nurse or Wound Specialist and ensure all residents who have ulcers greater than stage 2, are also referred if the ulcer deteriorates or a new area is developed as directed in the homes Skin and Wound Care program.

Grounds / Motifs :

1. The licensee failed to ensure that different approaches were considered in the revision of the plan of care when the plan of care was being revised because the care set out in the plan had not been effective.

An observation in 2017, revealed resident #017 had a dressing on an identified area. In an interview on the same day, the resident confirmed they had an alteration of skin integrity on the area.

A review of resident #017's clinical health record indicated they had an alteration of skin integrity on an identified area. Documentation on an identified date confirmed the alteration of skin required specific treatments and had worsened.

A review of a document in the home's Skin and Wound Care program binder titled "Team Members Roles and Responsibilities" indicated the DOC or skin care coordinator should make a referral to an Enterostomal (ET) Nurse for specified types of altered skin integrity or when there are difficulties in healing. A review of a document from the program titled "Pathway to Assessment/Treatment of Skin Tears" indicated that for specified types of altered skin integrity, a referral should be made to an ET or wound and skin specialist; consult Physician and ET therapist for review of treatment plan for identified parameters.

In interviews in 2017, PSW staff #117 and RPN staff #113 stated resident #017 had an alteration of their skin integrity for several weeks which was being treated. The PSW stated the home had tried several specified interventions, however; the resident refused them. RN staff #108 further stated the home tried additional interventions but they not effective for identified reasons.

In an interview in 2017, RPN #101 confirmed the alteration in skin integrity was not healing. When questioned by an LTCH Inspector as to why the resident was not referred to an ET nurse or Wound Specialist, they stated they had planned to notify the DOC to make a referral.

In an interview in 2017, the DOC confirmed staff had not followed the Skin and Wound program procedure for caring for resident #017's skin integrity, and a referral to an ET Nurse or Wound Specialist had not been made but should have been.

The home did not ensure that when the care set out in the plan of care had not been effective in the treatment of resident #017's skin integrity, different approaches had been considered in the revision of the plan of care.

(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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 24th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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