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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2018	2018_526645_0015	011685-17, 000870-18, 003130-18, 003143-18	Critical Incident System

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

DEREGE GEDA (645), IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): This inspection was conducted on the following date(s): November 1, 2, 5, 6, 7, 8, 9, 12, 13, 14 and 19, 2018.

During the course of the inspection, the following Critical Incident intake logs were inspected:
- Intake #011685-17 and #000870-18: related to incident of fall and
- Follow up intake #003130-18 and #003143-18, related to Bed rails and Fall program.

A Voluntary Plan of Action related to LTCHA, 2007, c.8, s. 6(7) was identified in this inspection and has been issued in a complaint report #2018_769646_0019, dated December 21, 2018, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Family Members.

The inspectors conducted observations of medication administration, staff to resident interactions, provision of care, record review of residents' and home records, staff training records, staffing schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Safe and Secure Home

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2017_547591_0017	645
O.Reg 79/10 s. 48. (2)	CO #002	2017_547591_0017	645

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	Légende 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. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On January 8, 2018, the following compliance order (CO) #001 from inspection number 2017_547591_0017, made under O.Reg 79/10, s. 15. (1) , was served:

The licensee shall complete the following:

1. Develop and implement 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 a clinically appropriate bed safety assessment 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 a clinically appropriate 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 clinically appropriate bed rail assessment tool and the home's requirements for bed safety assessment.

The compliance date was March 15, 2018.

The licensee completed steps one, two, four, and five in CO #001.

On November 15, 2018, the home's new assessment tool, titled "Resident Bed Safety & Sleep Assessment", was reviewed and met the requirement for CO #001, step one.

On November 15, 2018, three residents (#002, #004, #023) who used one or more bed rails were selected for review to determine if the residents were assessed using the clinically appropriate bed safety assessment tool and to determine that the assessed results and recommendations for each resident were documented. Review of resident #023's records indicated that the Resident Bed Safety & Sleep Assessment was not completed for the resident.

Interview with the Director of Care (DOC) indicated that the Resident Bed Safety & Sleep Assessment had not been done for resident #023 as the home had wanted to determine if the bed rails could be removed for the resident, but the resident had declined to remove the bed rails. The DOC indicated the Resident Bed Safety & Sleep Assessment should have been completed for resident #023 and it was missed. The DOC further indicated that the assessment has been initiated for resident #023 and will be completed and reviewed immediately.

The licensee failed to complete step three of CO #001 for resident #023, to assess all residents who use one or more bed rails using a clinically appropriate bed safety assessment tool and document the assessed results and recommendations for each resident. [s. 101. (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 comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act, to be implemented voluntarily.

WN #2: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (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 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 has failed to ensure that staff and others who provide direct care to a resident have convenient and immediate access to the plan of care.

During the inspection of a CIS report, PSW #103 indicated they do not have access to resident #010's care plan/kardex. The PSW revealed that all PSW staff at the home receive verbal shift report at the beginning of their shift but do not have direct access to residents' plan of care.

Interview with PSWs #105, #113 and #114 confirmed that PSWs at the home do not have access neither to the printed nor to the electronic copy of the residents' care plan/kardex. They indicated that they rely on the information shared during shift report at the beginning of shift to provide care to the residents. PSW #105 indicated that the home used to print residents' care plan and file it in a binder many years ago but that practice was stopped. During the interview, Inspector #645 requested the PSWs to demonstrate how they would access residents' care plan but all the above mentioned PSWs were unable to demonstrate how to access the care plan/kardex on the computer system.

Interview with RPN #112 indicated that all PSWs should have access to residents' plan of care. They are expected to review the plan of care for each resident prior to providing care. RPN #112 requested PSW #113 and #114 to access resident #010's kardex/ care

plan on the computer but they were unable to access it.

Interview with the DOC confirmed that all PSWs should have access to residents' plan of care/kardex and are expected to review the plan of care for each resident prior to providing care. The DOC stated that all PSWs were trained how to access the plan of care when the home implemented the Medi-Care computer system a few years ago. [s. 6. (8)]

2. The licensee has failed to ensure that when a resident was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Review of a CIS report, submitted to MOHLTC, indicated that resident #011 had an unwitnessed fall on an identified date and sustained an injury.

Record review of the progress note indicated that the resident also had multiple falls prior to the above mentioned identified date.

The resident's care plan was updated with fall prevention interventions after they sustained injury following the last fall incident. Further record review indicated that the plan of care was not updated, and no new interventions were implemented for the fall incidents prior to the identified fall mentioned above.

Interview with the DOC and RPN #112 indicated that when a resident has a fall, registered staff are expected to reassess the resident, develop interventions to prevent further falls and update the plan of care. In the event where the resident continues to fall, staff are to develop different approaches to prevent the fall from happening again and modify the plan of care with new interventions. They reiterated that recurring falls are the result of unmet or ineffective interventions and requires reassessment to prevent further fall incidents and injuries. Both the DOC and RPN #112 confirmed that registered staff neither used a different approach, nor implemented different interventions to prevent resident #011 from having recurring falls.[s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if: The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

This inspection was initiated as a follow up of compliance order (CO) #001, from report 2017_547591_0017 related to O. Reg. 79/10, s. 15 (1) The licensee shall ensure 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; and (b) steps are taken to prevent

resident entrapment, taking into consideration all the potential zones of entrapment. Resident #002 was included as part of the resident sample to inspect on the follow-up CO #001.

Review of resident #002's most recent care plan showed that the resident required identified side rails for bed mobility, and the resident uses the identified rails while in bed as a Personal Assistance Service Device (PASD).

Review of the home's policy titled "Use of a PASD" date reviewed March 23, 2018, indicated: The prescribing clinician is required to obtain informed consent for the treatment from the resident and or the substitute decision-maker (SDM), and to obtain and record informed consent, including that the risks and benefits of alternative treatment options and risks and benefits related to the use of the PASD have been outlined to the resident/SDM.

Review of resident #002's Resident Bed Safety & Sleep Assessment indicated that the resident was assessed by registered staff and the physiotherapist (PT) for use of the bed rails when the resident was in bed.

Review of resident #002's progress note on an identified date, indicated that the resident's SDM had not signed the annual consent for resident #002's Personal Assistance Service Device (PASD) Consent form, and progress note indicated that the DOC will continue to work with the resident and family to obtain or update required consents.

Interview with RPN #112 indicated that resident #002's Personal Assistance Service Device (PASD) Consent form for the use of the above mentioned identified bed rails was not included in the resident's clinical record, and the RPN was not able to find the consent form.

Interview with the Director of Care (DOC) indicated that for all residents who use PASDs, consent should be obtained, documented, and kept in the resident's chart. The DOC indicated that the home is working with the resident's SDM to obtain the consent, but the SDM consent has not yet been obtained and documented, and the PASD Consent form was not signed by the resident's SDM. [s. 33. (4) 4.]

Issued on this 4th day of January, 2019

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

Original report signed by the inspector.