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

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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_769646_0019	006533-17	Complaint

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

IVY LAM (646), DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6, 7, 8, 9, 13, 14, 15, 16, and 19, 2018.

The following intake was completed in this complaint inspection:
Log #006533-17 was related to pain management, provision of care, and food quality in the home.

A Voluntary Plan of Action related to LTCHA,2007, c.8, s. 6(7), identified in a concurrent critical incident inspection #2018_526645_0015 (Log #011685-17, CIS #1078-000003-17) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Pharmacist, Food Service Supervisor, Dietary Aide, Residents, Family Members, and Substitute Decision Makers (SDM).

During the course of this inspection, the inspector conducted a tour of the home, dietary serveries, the home's production kitchen, observed dining room services, residents' home areas, residents' care, staff to resident interactions, and reviewed residents' health care records and the home's records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Food Quality
Medication
Personal Support Services

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in the plan of care was provided to the resident as specified in the plan.

This inspection was initiated related to an anonymous complaint received by the Ministry of Health and Long-Term Care (MOHLTC) related to concerns regarding resident #020's pain management, provision of care for bathing, and the overall food quality in the home.

Review of resident #020's current care plan and kardex printed on an identified date indicated resident #020 required assistance for bathing. Interventions for bathing resident #020 included: prefers bathing on an identified day of the week at an identified time period.

The same care plan for resident #020 further detailed interventions for the resident's resistance to treatment and refusal of care. The interventions included:
- Document care being resisted on the multidisciplinary notes (MDN),
- Elicit family input for best approaches to resident #020,
- Inform the resident of the activity of daily living (ADL) that is required ahead of timed and give the resident two options of times to be done to give resident #020 choice and

allow for flexibility in routines,
- Allow flexibility with ADL's to accommodate mood changes,
- If resident #020 refuses, leave and return.

Review of resident #020's Observation/Flow Sheet Monitoring on Point of Care (POC), printed on an identified date showed the resident's history of bathing care on the identified day of the week for a four-month period showed:
- First month: Bathing care received once and refused on three other weeks of the month.
- Second month: Bathing care received on three weeks and refused on the two other weeks of the month.
- Third month: Bathing care received on two weeks and refused on the two other weeks of the month.
- Fourth month: Bathing care refused on two weeks (note the inspection occurred on this month)

Review of the MDN progress notes did not indicate any documentation related to the refusal of bathing care, or any documentation of eliciting family input on the abovementioned dates where bathing care was refused by resident #020.

Interview with Personal Support Worker (PSW) #110 who has provided bathing care multiple times for resident #020 on a particular shift indicated that on resident #020's bathing days, the PSW would inform resident #020 it is their bathing day, and that they are there to provide assistance with bathing. If the resident refuses, the staff goes and returns in 20-25 minutes, or when the resident rings the call bell, and offers again. If the resident continues to refuse bathing, the PSW stated they would inform the nurses, and the nurses would inform the family.

Interview with Registered Practical Nurse (RPN) #108 indicated that the PSWs have informed the RPN when the resident refused bathing, and the RPN would ask staff to try again. RPN #108 stated they have not contacted the family for input or best approaches related to refusal of bathing. They did not document refusal of bathing in the MDN as the RPN had thought the PSWs had provided bathing care when they reapproached the resident. When RPN #108 reviewed the flowsheets for bathing from POC, including the dates the RPN had worked, the RPN stated they had not contacted the family on those dates, and there was no documentation in resident #020's MDN.

Interview with Registered Nurse (RN) #107 indicated that the home has tried many interventions to encourage resident #020 to bathe, and the PSWs have informed RN #107, but the home has not called the family for input for best approaches when resident #020 refuses bathing care. Furthermore, RN #107 did not document the care refused when resident #020 refused bathing care, as per resident #020's care plan.

Interview with the Director of Care (DOC) indicated the care set out in the plan of care was not provided to the resident as specified in the plan when resident #020 refused bathing care. [s. 6. (7)]

2. Record review of a Critical Incident System (CIS) report submitted to the MOHLTC, indicated that resident #010 had a fall on an identified date.

Record review of a progress note on the date of the incident indicated that resident #010 fell after attempting to get out of their bed sustaining an injury. The home completed a post fall assessment, and developed interventions to prevent further falls. The interventions included to keep the call bell within reach, place an alarm system on resident #010's bed and check functionality of the alarm as a safety precaution. The review of the post fall assessment indicated that the resident was found on the floor next to their bed and the bed alarm was not functioning at the time. Record review of the home's internal investigation notes indicated that staff placed the bed alarm cord on the resident but the alarming device box was missing.

On an identified date at an identified time, resident #010 was observed laying in bed in their room. A fall prevention alarming device was observed on the side table and was not attached to the resident.

Inspector #645 immediately contacted the primary PSW #103 and they confirmed that the alarming device on the side-table was not attached to the resident. PSW #103 stated that the plan of care directed staff members to attach the alarming device when the resident is in bed. They reiterated that the alarming device was supposed to alert staff members when the resident attempts to get out of bed.

Interview with the DOC confirmed that when resident #010 had a fall on the identified date mentioned above, the fall alarming device was not functioning. They confirmed that the plan of care directed staff members to check functionality of the alarming device for safety and to attach it to the resident to prevent falls. They reiterated that staff members

are expected to provide care as specified in the plan of care, and confirmed that resident #010 did not receive care as specified in the plan. [s. 6. (7)] (645). [s. 6. (7)]

3. The licensee shall ensure that the provision of the care set out in the plan of care was documented.

This inspection was initiated related to an anonymous complaint received by the MOHLTC, related to concerns regarding resident #020, including provision of bathing care. Resident #022 was included as part of the sample expansion when a finding of non-compliance was identified related to bathing care for resident #020.

Review of the Day Shift Bath List in an identified shower room showed resident #022's identified days of the week for the resident's first and second bathing care, and that was to be provided during an identified shift.

Review of resident #022's Observation/Flow Sheet Monitoring form printed on an identified date for a four-month period showed that resident #022 had bathing care independently with no setup assistance.

The records also indicated that the resident refused bathing care on the following dates:
- First month: two identified dates,
- Second month: one identified date,
- Third month: two identified dates.

The records indicated that bathing activity did not occur on the following dates:
- First month: 14 identified dates,
- Second month: 14 identified dates,
- Third month: 13 identified dates,
- Fourth month: two identified dates.

Interviews with resident #022 indicated that they bathe twice a week independently, and did not need staff to assist. The resident was not able to recall their scheduled bathing days.

Interviews with PSWs #103 and #106 indicated that resident #022 prefers bathing on a different identified shift than what was on the resident's written plan of care, and bathes independently, but that they would prepare a towel for the resident and check to make sure they are safe. The PSWs further stated that resident #022 had been bathing

independently for a long time, and were not able provide a specific length of time. Interview with RN #111 indicated resident #022 was able to bathe on their own, and the RN had seen resident #022 come out of the shower room.

Interview with the DOC indicated that the licensee did not ensure that the provision of care related to resident #022's bathing care was documented, as the resident had bathed independently over the course of the four months reviewed, but the documentation indicated that the bathing activity did not occur. [s. 6. (9) 1.]

4. The licensee has failed to ensure 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.

This inspection was initiated related to an anonymous complaint received by the MOHLTC, related to concerns for resident #020, including provision of bathing care. Resident #022 was included as part of the sample expansion when a finding of non-compliance was identified related to bathing care for resident #020.

Review of the Bath List on an identified shift in an identified residents' shower room showed resident #022 was to receive their baths on two identified dates of the week and the bathing care was to be provided during an identified shift.

Review of resident #022's current written care plan showed that the resident required an identified level of assistance for bathing. Bathing care interventions for the resident included: staff to apply soap to wash cloth and give to resident #022 to wash themselves.

Interviews with resident #022 indicated that they bathe twice a week independently. The resident further stated that they do not need staff to assist. The resident was not able to recall their scheduled bathing days.

Interviews with PSWs #103 and #106 indicated that resident #022 had a particular preference related to bathing care on an identified shift different from what was listed in the resident's written plan of care, and bathes independently, but that staff would check to make sure the resident was safe. The PSWs further stated that resident #022 had been bathing independently for a long time, and were not able provide a specific length of time.

Interview with RN #111 indicated resident #022 was able to bathe on their own, and the RN had seen resident #022 come out of the shower room. RN #111 further stated that bath list in the shower room needs to be updated to reflect the shift that resident #022 bathes on, and the bathing care plan needs to be updated to reflect the level of care and interventions resident #022 needs.

Interview with the DOC indicated that resident #022's care plan did not accurately reflect the assistance for bathing care that the resident currently needed. They stated that the bath list should also reflect that the resident's preferred shift for bathing. The DOC further indicated that resident #022's plan of care for bathing, including the bath list, had not been revised when the resident's care needs changed or the care set out in the plan of care is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, the provision of the care set out in the plan of care is documented, and the resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Record review of a complaint report submitted to the MOHLTC, via the INFOLine indicated that resident #020 had been receiving inconsistent treatment of a medical condition.

Record review of the physician order and Medication Administration record (MAR) on an identified date indicated that resident #020 was prescribed two different medications for an identified medical condition. An identified medication for when the resident experiences an exacerbation of an identified medical condition, and a second identified medication to be given 'pro re nata' (PRN or 'as needed').

Review of the progress note dated on another identified date, indicated that resident #020 experienced an exacerbation of an identified medical condition. Record review of the MAR on the identified date did not indicate that the first identified medication was administered. The MAR indicated that resident received the second identified medication.

Review of the progress note on a second identified date indicated that resident #020 experienced an exacerbation of the above mentioned identified medical condition. Record review of the MAR on the identified date indicated that that neither the first nor the second identified medication was administered to the resident.

Review of the progress note on a third identified date indicated that resident #020 experienced an exacerbation of the above mentioned identified medical condition. Record review of the MAR on the identified date did not indicate that the first identified medication was administered. The MAR indicated that resident had received the second identified medication.

Review of the progress note on a fourth identified date indicated that resident #020 experienced an exacerbation of the above mentioned identified medical condition. Record review of the MAR on the identified date indicated that that neither the first nor the second identified medication was administered to the resident.
Interview with Pharmacist #115 indicated that registered staff are to administer the first identified medication when the resident experiences an exacerbation of the above mentioned identified medical condition. They stated that the second identified medication can be applied when needed.

Interviews with RN #116 and RPN #107 confirmed that the physician's order directed staff to provide the first identified medication when the resident experiences an exacerbation of the above mentioned identified medical condition. They acknowledged that the resident did not receive the appropriate treatments on the above mentioned dates.

Interview with the DOC indicated that registered staff are to administer medication to the resident as prescribed by the physician. They confirmed that resident #020 did not receive appropriate treatment for their identified medical condition as directed by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.