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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2017	2017_601532_0003	004237-17	Resident Quality Inspection

Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES
200 Boullee St. New Hamburg ON N3A 2K4

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

NITHVIEW HOME
200 Boullee Street New Hamburg ON N3A 2K4

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

NUZHAT UDDIN (532), DOROTHY GINTHER (568), MARIAN MACDONALD (137), SHARON PERRY (155), SHERRI GROULX (519)

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 7, 8, 9, 10, 13, 14, 15, 16, 17, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):
Follow up to inspection 2016_226192_0028 including the following orders:
Follow-up log #030835-16 CO#001 related to duty to protect;
Follow-up log #030835-16 CO#002 related to doors;
Follow-up log #030835-16 CO#003 related to skin and wound care.

Critical Incident Log # 031030-16 related to alleged abuse;
Critical Incident Log # 032243-16 related to missing resident;
Complaint Log # 032510-16 related to staffing level.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Acting Executive Director, Acting Director of Care (ADOC), Assistant Director of Cares (ADOC), Nutrition Manager, Registered Dietitian, Manager of Environmental Services, Resident Assessment Instrument (RAI) Coordinator, Behaviour Support Ontario Staff (BSO), Registered Nurses, Registered Practical Nurses, Staff Scheduler, Personal Support Workers, Dietary Aide, Recreation Care Aide, Housekeeping and Maintenance staff, Family, Resident Council Representatives, and over forty residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **15 WN(s)**
- **8 VPC(s)**
- **4 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. 19. (1)	CO #001	2016_226192_0028	137
O.Reg 79/10 s. 50. (2)	CO #003	2016_226192_0028	532
O.Reg 79/10 s. 9. (1)	CO #002	2016_226192_0028	137

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of the anonymous complaint related to staffing shortages and concerns related to baths not getting done were received during stage one of the Resident Quality Inspection (RQI).

A specified resident raised concerns and shared that agency staff don't know the plan of care.

Another specified resident shared that the agency staff don't know what they are doing.

During an interview, Acting Director of Care (ADOC) said agency staff do not get a full orientation shift and were not orientated, as per the Long Term Care Homes Act legislative requirements.

During an interview, Staff Scheduler said that Executive Director had planned to modify the home's orientation checklist to accommodate agency staff but that never happened. They shared that agency staff were not orientated as per the legislative requirements.

The Staff Scheduler said that agency Registered Nurses (RN's) were given four hours orientation and agency Registered Practical Nurses (RPN's) were given two – four hours orientation working alongside the home's regular registered staff. Agency Personal Support Workers (PSW's) would come in an hour or two before their scheduled shift for orientation with the home's regular PSW's, if the agency PSW's were available to do so.

During an interview, the Acting Executive Director said they were aware that agency staff required orientation but it had not happened as the home had to ensure adequate staffing coverage to care for and meet the needs of the residents.

The licensee has failed to ensure that no person, including agency staff, performed their responsibilities before receiving training.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation [r.76 (4)] being issued in the home on April 17, 2014, in a CIS 2014_183135_0026 as a Written Notification. [s. 76. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device was included in the plan of care.

During observations an identified resident was observed with a physical device. The resident was asked if they could remove their physical device and on both occasions the identified resident did not respond and did not demonstrate the ability to remove their physical device.

The Acting Director of Care (ADOC) told this Inspector that when the identified resident first had the physical device applied, it was a Personal Assistance Services Device (PASD) and not a restraint. At that time the resident was apparently able to remove the physical device.

During a review of resident physical chart and the electronic plan of care there was no documentation of an order by the physician or a registered nurse in the extended class specific.

The Acting Director of Care (ADOC) acknowledged that the identified resident was not able to remove the physical device, that it was a restraint, and that there was no order by the physician for the restraining device and acknowledged that it was not included in the plan of care.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was pattern during this inspection. There was a compliance history of this legislation [r.31(3)] being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as a Voluntary Plan of Correction and issued on September 14, 2015, in a RQI 2015_271532_0025 as a Written Notification. [s. 31. (1)]

2. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried but have not been effective in addressing the risk.

An identified resident was seen with the physical device.

There was no documentation in the plan of care of an assessment related to the use of physical device/ restraint that included alternatives to the use of the physical device that were considered and tried, but had not been effective in addressing the risk.

During an interview with the lead for the restraints program RPN, they shared that the identified resident had a physical device applied for a long time. The Acting DOC told the Inspector that they were not able to find documentation as to the alternatives that were considered and tried for the identified resident prior to administering the restraint.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was pattern during this inspection. There was a compliance history of this legislation [r.31(3)] being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as a Voluntary Plan of Correction and issued on September 14, 2015, in a RQI 2015_271532_0025 as a Written Notification. [s. 31. (2) 2.]

Additional Required Actions:

CO # - 001, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

During interviews with two identified Personal Support Workers they said they participated in an annual education day which reviewed a number of different topics. When asked if falls prevention and management was one of the programs reviewed and discussed they could not recall.

The Acting Director of Care told the Inspector that falls prevention and management was not a part of their annual education. Currently, for newly hired staff they review the orientation binder and staff sign off on the relevant policies. The acting Director of Care was unsure if falls prevention and management was a part of this orientation.

During a review of the orientation binder provided to the Inspector it was noted that there was no information related to falls prevention and management. The 2016 annual education schedule was also reviewed and there was nothing on the agenda regarding falls prevention and management.

The Physiotherapist told the Inspector that they had not provided education to staff regarding falls prevention and management. The Physiotherapist said that in the past they had conducted some in-services regarding safe lifting, ergonomics and falls prevention but the last time this was done was 2015.

The licensee failed to ensure that direct care staff were provided training in falls prevention and management.

The severity was determined to be a level a level one as there was minimum harm. The scope of this issue was widespread during the course of this inspection. There was compliance history of this legislation [r. 221(2)] issued September 14, 2015, in a RQI 2015_271532_0025 as a Voluntary Plan of Correction and [r. 221(1)1] issued May 5, 2014, in a CIS 2014_217137_0012 as a Voluntary Plan of Correction. [s. 221. (1) 1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident and that the staffing plan would be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A specified resident raised concerns that the home needed more staff and shared that agency staff don't know the plan of care.

Another specified resident shared that on the weekends the home was short of PSWs and replaced with agency staff but they don't know what they are doing.

Family Council representative shared that the biggest concern that was raised at the meeting was staffing, that there was not enough staff to meet the needs of the residents.

A review of the staffing plan with Staff Scheduler showed that the plan required 27 Personal Support Workers (PSW) for the full 24 hours, 12 for the day shift, nine for the evening shift and six for the night shift.

During an interview, Staff Scheduler said there were a total of nine vacant part-time lines for PSW's. Human Resources (HR) department has been trying to recruit to reach the full complement to fill all vacancies.

With Staff Scheduler, the Inspector reviewed the number of agency staff utilized by the home between January 1, 2017 and February 28, 2017, which showed the following:

January 2017: 9.5 Registered Nurse (RN) shifts out of 93 shifts (10.21%); three Registered Practical Nurse (RPN) shifts out of 217 shifts (1.38%); 73 Personal Support Worker (PSW) shifts of the 837 shifts (8.72%)

February 2017: four RN shifts out of 84 shifts (4.76%); nine RPN shifts out of 196 shifts (4.59%); 40 PSW shifts out of 746 shifts (5.36%)

From January 1, 2017 to February 28, 2017: 13.5 RN shifts (14.97%); 12 RPN shifts (5.87%); 113 PSW shifts (14.08%) were covered by agency staff.

During an interview, the Acting Executive Director said that utilizing a variety of agency staff did not promote the continuity of care to the residents and the home's priority was to minimize and eventually eliminate the use of agency staff. The Acting Executive Director also said that the home's staffing plan was not evaluated and updated annually but was in the process of undergoing a significant update and evaluation.

The severity was determined to be a level one as there was minimum risk, the scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as Voluntary Plan of Correction; issued on September 14, 2015, in a RQI 2015_271532_0025 as a Written Notification. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident and that the staffing plan would be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 plan of care set out clear directions to staff and others who provide direct care to the resident.

Review of the plan of care for a specified resident indicated that they had altered skin integrity.

The plan of care under altered skin integrity provided interventions to the staff.

The Kardex provided different directions to the Personal Support Workers (PSW) under resident care.

Resident observation showed that interventions were not followed as per plan of care or the Kardex.

In an interview RPN was not able to indicate which interventions were to be in place and acknowledged that for consistency the care plan and Kardex should match to provide clear directions to staff who provide direct care to the resident.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation [s.6 (1)(c)] being issued in the home on September 7, 2016, in a Resident Quality Inspection 2016_226192_0028 as a Voluntary Plan of Correction (VPC); issued [s.6 (1)(c); s.6(10) (b); s.6(7);6 (9) 1] on September 14, 2015 in a Resident Quality Inspection 2015_271532_0025 as a Voluntary Plan of Correction (VPC); issued [s.6 (1)(c)] on April 21, 2015, in a Complaint inspection 2015_262523_0008 as a Voluntary Plan of Correction; issued [6 (1) (a)] April 30, 2014, in a Complaint inspection 2014_226192_0015 as a Voluntary Plan of Correction. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Record review identified that a specified resident had food intolerance to specific food items.

The Power of Attorney (POA) shared that the identified resident had intolerance to certain food due to their diagnosis. The POA shared that they tried to meet with the Registered Dietitian to discuss the identified resident's needs after resident's admission.

Record review indicated that the POA requested to have a conversation with the Registered Dietitian (RD) related to resident's condition.

The POA indicated that they did not find the meeting with the RD to be productive. They shared that they continued to provide the home staff with directions on the food choices for the identified resident. They acknowledged that neither Nutritional Manager nor the RD had come to discuss resident's status or the menu items since the initial meeting.

The POA reviewed the revised menu with the Inspector and it appeared that the POA was bringing food from home.

The Nutrition Manager shared that they were not aware that the POA had added new items on the list and that they had not discussed other options in terms of bringing food from home as they didn't realize that certain food items were offered so frequently on the menu.

The RD acknowledged that they had not been made aware of the new items that had been added on the list by the POA and acknowledged that they did not have another meeting to discuss residents' health status and presumed that the resident was doing well as there were no reported health concerns as per the documentation in the progress notes and MDS.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation [s.6 (1)(c)] being issued in the home on September 7, 2016, in a Resident Quality Inspection 2016_226192_0028 as a Voluntary Plan of Correction (VPC); issued [s.6 (1)(c); s.6(10) (b); s.6(7);6 (9) 1] on September 14, 2015 in a Resident Quality Inspection 2015_271532_0025 as a Voluntary Plan of Correction (VPC); issued [s.6 (1)(c)] on April 21, 2015, in a Complaint inspection 2015_262523_0008 as a Voluntary Plan of Correction; issued [6 (1) (a)] April 30, 2014, in a Complaint inspection 2014_226192_0015 as a Voluntary Plan of Correction. [s. 6. (2)]

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

An identified resident was observed with a physical device.

Interventions related to the physical device were documented in the plan of care for the identified resident.

The Acting Director of Care (ADOC) told this Inspector that when the identified resident first had the physical device applied, it was deemed a Personal Assistance Services Device (PASD) and not a restraint.The ADOC acknowledged that the identified resident had not been reassessed and the plan of care had not been reviewed and revised when the resident's care needs changed.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation [s.6 (1)(c)] being issued in the home on September 7, 2016, in a Resident Quality Inspection 2016_226192_0028 as a Voluntary Plan of Correction (VPC); issued [s.6 (1)(c); s.6(10) (b); s.6(7);6 (9) 1] on September 14, 2015 in a Resident Quality Inspection 2015_271532_0025 as a Voluntary Plan of Correction (VPC); issued [s.6 (1)(c)] on April 21, 2015, in a Complaint inspection 2015_262523_0008 as a Voluntary Plan of Correction; issued [6 (1) (a)] April 30, 2014, in a Complaint inspection 2014_226192_0015 as a Voluntary Plan of Correction. [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 plan of care set out clear directions to staff and others who provide direct care to the resident; to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences; to 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 the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, they were assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Record review showed that an identified resident had a fall. There was no documentation of a post falls assessment and the most recent falls risk assessment was completed on admission.

The acting Director of Care and the RPN/Falls Lead shared that it was the home's expectation that for every fall the registered staff completed a post fall assessment on Point Click (PCC) and a falls risk assessment. The Acting Director of Care acknowledged that there was no documentation that a post fall assessment and falls risk assessment were conducted.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as Voluntary Plan of Correction. [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 has fallen, they are assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, of which included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A review of the medication incidents and adverse medication reactions in the home for three months were reviewed and the last quarterly review of the medication incidents were discussed with the Acting Director of Care (ADOC). Inspector asked the ADOC when the last quarterly review of the above incidents were done.

The Acting DOC stated that it was during the Professional Advisory Committee (PAC) meetings where the medication incidents were discussed. It was stated that there had been a PAC meeting in June 2016, but that due to the home's Resident Quality Inspection (RQI) back in September 2016, the prior DOC held a meeting in September 2016 with only the Pharmacist from Remedy Pharmacy. The subsequent PAC meetings that were scheduled in October and December 2016 had been cancelled. It was stated that the next scheduled PAC meeting would be held in March 2017. Therefore, the medication management system in the home had not been reviewed since June 2016.

The severity was determined to be a level a level one as there was minimum harm. The scope of this issue was widespread during the course of this inspection. There was compliance history unrelated to this legislation being issued in the home. [s. 115. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team, of which included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meet at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device was undertaken on a monthly basis.

During a review of the home's restraint program there was no evidence that an analysis had been undertaken of the restraining of residents by use of a physical device.

The Acting Director of Care (ADOC) told Inspector that the home had not completed a monthly analysis of the restraining of residents by use of a physical device.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was widespread during the course of this inspection. There was a compliance history unrelated to this legislation being issued. [s. 113. (a)]

2. The licensee has failed to ensure that a written record was kept, that was promptly prepared of the monthly analysis, the annual evaluation and the changes and improvements required; the date of the annual evaluation; the names of the persons who participated in the evaluation; and the date that the changes were implemented.

During an interview with the Acting Director of Care (ADOC) they said that the home had not yet completed the 2016 annual program evaluations. The ADOC shared that they were not able to access the 2015 annual evaluation for minimizing of restraining because it was believed that a previous staff had removed it from the home. The Acting Administrator acknowledged that the home did not have the 2015 program evaluation related to minimizing of restraining.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was widespread during the course of this inspection. There was a compliance history unrelated to this legislation being issued. [s. 113. (e)]

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 an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis and to ensure that a written record is kept, that is promptly prepared of the monthly analysis, the annual evaluation and the changes and improvements required; the date of the annual evaluation; the names of the persons who participated in the evaluation; and the date that the changes are implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device was applied in accordance with manufacturer's instructions (if any).

An identified resident was seen with the physical device that was not applied in accordance with manufacturer's instructions.

A Personal Support Worker was asked if the physical device was applied properly, the PSW said that it was. When PSW was asked if they had been provided with education with regards to the proper application of the physical device, the staff member said they did not think so.

On a specified date the identified resident was again observed with the physical device

and it was not applied in accordance with manufacturer's instructions.

The Acting Director of Care (ADOC) told this Inspector that to their knowledge staff had not been provided education with respect to the proper application of physical devices in the last year. The ADOC could not provide the manufacturer’s instructions for the physical device but acknowledged that it had not been applied correctly when observed by this Inspector on more than one occasion.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued [r.110(2)3] on October 7, 2014, in a Complaint 2014_259520_0028, as a Voluntary Plan of Correction. [s. 110. (1) 1.]

2. The licensee has failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

During multiple observations the identified resident was observed with the physical device.

Review of the documentation for the identified resident did not show any evidence that the physical device was being monitored and reassessed at least every eight hours, and at any other time based on the resident's condition.

Registered Practical Nurse (RPN) told this inspector that for those residents that have a restraint, the registered staff were expected to monitor and assess the application of the physical device on each shift. They would do this by documenting for the identified resident. RPN acknowledged that there was no documentation that the resident was being reassessed and the effectiveness of the restraint evaluated at least every eight hours and at any other time based on the resident's condition.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued [r.110(2)3] on October 7, 2014, in a Complaint 2014_259520_0028, as a Voluntary Plan of Correction. [s. 110. (2)

6.]

3. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

Review of the plan of care for an identified resident showed an application of a physical device for prevention of injury. There were specific instructions including assessment, reassessment and monitoring resident's response to the physical device.

During a review of the resident's electronic clinical record and the physical chart there was no documentation of an assessment related to the application of the physical device, nor was there documentation that the resident had been reassessed including the resident's response to the use of the device for almost five year period that the physical device had been applied.

The RPN told this inspector that residents that have a physical device were to have an assessment prior to the device being applied. When the staff member checked the identified resident's clinical record they were unable to locate any assessments related to the resident's physical device. RPN acknowledged that there should have been an assessment and annual reassessments completed that would include the resident's response to the device.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued [r.110(2)3] on October 7, 2014, in a Complaint 2014_259520_0028, as a Voluntary Plan of Correction. [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the physical device is applied in accordance with manufacturer's instructions;
to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances; to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response., 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if:
(a) The staff member had been trained by a member of the registered nursing staff in the administration of topicals
(b) The member of the registered nursing staff who was permitting the administration was satisfied that the staff member could safely administer the topical; and
(c) The staff member who administered the topical did so under the supervision of the member of the registered nursing staff.

During an interview with Personal Support Workers (PSW), it was stated that they have been administering prescription topical creams to residents for years; having been employed in the home for thirty five and twelve years respectively.

During an interview with the Assistant Director of Care (ADOC), it was stated that the home introduced a new policy on PSW application of topical prescription medications, but that it had not been implemented in the home yet. They stated that it would be introduced at the next PSW meeting. ADOC stated it was not known if the PSW staff working at the home had all received the required education, delegation, and monitoring from a Registered staff in the application of topical prescription creams.

During an interview with the Acting Director of Care, it was stated that there was no evidence to show that training on the application of prescription creams had been provided to PSWs since the year 2013. Acting DOC stated that the employment records of several PSWs had been searched and that was the last date that could be found. Acting DOC stated that the home's policy stated that training was to be done by the Registered staff and that documentation for competency of the PSWs was to be completed and, it had not been done.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was pattern during the course of this inspection. There was compliance history unrelated to this legislation being issued in the home. [s. 131. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a member of the registered nursing staff permitted a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only; to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

As per the regulations “altered skin integrity” means potential or actual disruption of epidermal or dermal tissue.

An identified resident was observed to have an area of altered skin integrity.

Record review showed that a procedure was completed for the identified resident. The physician had ordered directions for staff to follow for the altered skin integrity.

During an interview with Registered Practical Nurse (RPN) shared that there should have been a skin assessment done using the assessment in point click care, however, it was not done.

The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as a Compliance Order; issued in the home on August 23, 2016, in a CIS 2016_226192_0026 as a Voluntary Plan of Correction and issued September 14, 2015 in a RQI 2015_271532_0025 as a Voluntary Plan of Correction. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours.

Record review of the Minimum Data Set Assessment for an identified resident showed that resident had a specific behaviour. Review of resident plan of care did not identify that they had a specific behaviour.

During interview Personal Support Worker shared that identified resident had a specific behaviour with activities of daily living.

Review of the documentation for the specified period of time showed that the identified resident had a specific behaviour with activities of daily living.

During interview with the Acting Director of Care they shared that the identified resident's plan of care did not identify that they had a specific behaviour and the interventions that staff used.

The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included: any identified responsive behaviours.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 14, 2015, in a RQI 2015_271532_0025 as Voluntary Plan of Correction [s. 26. (3) 5.]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to minimize the restraining of residents was complied with.

Review of the home's policy stated that physical restraints must be inspected a minimum of every hour and they must be removed/released a minimum every two hours when the resident was awake. Documentation of this monitoring should be completed hourly on the "Restraint Monitoring Record", while the device was in use.

Review of the point of care (POC) documentation related to restraints, indicated that an identified resident had a physical device applied. It was reported that the device was checked three times all documented at the same time. The next documentation was at two hours after when the physical device was removed.

Review of the point of care documentation for the identified resident related to restraints, showed that the resident had physical device at a specific time. It was also documented that the physical device was checked three times all at the same time. There was no documentation for the remainder of the day.

During an interview with the Acting Director of Care they shared that staff document the monitoring of all physical restraints on point of care. This would be done on an hourly basis. When shown the documentation for resident the ADOC was unsure why all the documentation was recorded at the same time. The ADOC said that the documentation should not occur all at one time and should reflect the time that the checks and repositioning were conducted. The ADOC acknowledged that staff had not complied with their restraint monitoring process as outlined in the home's policy.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was isolated during the course of this inspection. There was a compliance history unrelated to this legislation being issued [s. 29. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the process for reporting and locating residents' lost clothing and personal items was implemented.

During stage one of the Resident Quality Inspection (RQI) an identified resident told the inspector that they had missing clothing and it was never found.

During an interview with Laundry Aide they told this inspector that when a resident reports a missing clothing item to staff they were expected to contact laundry so they can conduct a search. If the item was not found immediately then it was recorded in their "Missing Laundry" binder with a description of the item and name of the resident. Laundry staff then conduct a search of the resident's room, areas around the room and the laundry room. If the item was found then the date it was found would be recorded in the binder titled "Missing Laundry".

Review of the Missing Laundry binder identified a number of articles of clothing that were reported missing. Beside some of the articles a date was documented when the article was found. There were several articles did not have a found date identified. There was no documentation of the identified resident missing clothing.

The Director of Environmental Services (DES) told this inspector that laundry staff said they were aware that resident was missing clothing and acknowledged that the item should have been recorded in the Missing Laundry binder so that staff were aware and continuing to look for the item. The DES also told this inspector that when the item was not found it was the home's process that the DES update the resident as to the progress of the search and outcome. DES acknowledged that they had not spoken with the identified resident to update them on the outcome of their search.

The licensee failed to implement their procedure for reporting and locating residents' lost clothing and personal items.

The severity was determined to be a level one as there was minimum harm. The scope of this issue was isolated during the course of this inspection. There was compliance history unrelated to this legislation being issued in the home. [s. 89. (1) (a) (iv)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed related to a missing resident who returned to the home with an injury and required medical attention by the attending physician.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of a missing resident with injury, which occurred on specified date, however, the Director was not immediately informed related to a missing resident.

A review of the Risk Management Report, showed documented evidence that the Director of Care (DOC) and Assistant Director of Care (ADOC) were made aware of the incident by Registered Nurse (RN) at the time of occurrence.

During an interview the Acting Director of Care (DOC) said that Executive Director (ED) and DOC were aware of the incident but did not feel it was to be reported, as the identified resident was missing less than three hours, from the home.

The Acting DOC was an Assistant Director of Care at the time of the incident. When they assumed the role of Acting DOC, they checked the Critical Incident System (CIS) and saw that no CIS report had been submitted and that the Director had not been immediately informed related to a missing resident who returned to the home with an injury.

The licensee has failed to ensure that the Director was immediately informed related to a missing resident who returned to the home with an injury and required medical attention by the attending physician.

The severity was determined to be a level one as there was minimum harm. The scope of this issue was isolated during the course of this inspection. There was compliance history unrelated to this legislation being issued in the home. [s. 107. (1) 4.]

Issued on this 29th day of June, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur
Aux termes 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), DOROTHY GINTHER (568), MARIAN MACDONALD (137), SHARON PERRY (155), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2017_601532_0003
Log No. / Registre no:	004237-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 27, 2017
Licensee / Titulaire de permis :	TRI-COUNTY MENNONITE HOMES 200 Boullee St., New Hamburg, ON, N3A-2K4
LTC Home / Foyer de SLD :	NITHVIEW HOME 200 Boullee Street, New Hamburg, ON, N3A-2K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephen Lichty

To TRI-COUNTY MENNONITE HOMES, 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 :

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

Order / Ordre :

The licensee shall ensure that restraint by a physical device is included in the plan of care for an identified resident and all other residents that may be restrained by a physical device as described in paragraph 3 of subsection 30 (1).

Grounds / Motifs :

1. The licensee has failed to ensure that restraint by a physical device was included in the plan of care.

During observations an identified resident was observed with a physical device. The resident was asked if they could remove their physical device and on both occasions the identified resident did not respond and did not demonstrate the ability to remove their physical device.

The Acting Director of Care (ADOC) told this Inspector that when the identified resident first had the physical device applied, it was a Personal Assistance Services Device (PASD) and not a restraint. At that time the resident was apparently able to remove the physical device.

During a review of resident physical chart and the electronic plan of care there was no documentation of an order by the physician or a registered nurse in the extended class specific.

The Acting Director of Care (ADOC) acknowledged that the identified resident was not able to remove the physical device, that it was a restraint, and that there was no order by the physician for the restraining device and acknowledged that it was not included in the plan of care.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was pattern during this inspection. There was a compliance history of this legislation [r.31(3)] being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as a Voluntary Plan of Correction and issued on September 14, 2015, in a RQI 2015_271532_0025 as a Written Notification. [s. 31. (1)] (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2017

Order # / Ordre no : 002 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

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

Review of the anonymous complaint related to staffing shortages and concerns related to baths not getting done were received during stage one of the Resident Quality Inspection (RQI).

A specified resident raised concerns and shared that agency staff don't know the

plan of care.

Another specified resident shared that the agency staff don't know what they are doing.

During an interview, Acting Director of Care (ADOC) said agency staff do not get a full orientation shift and were not orientated, as per the Long Term Care Homes Act legislative requirements.

During an interview, Staff Scheduler said that Executive Director had planned to modify the home's orientation checklist to accommodate agency staff but that never happened. They shared that agency staff were not orientated as per the legislative requirements.

The Staff Scheduler said that agency Registered Nurses (RN's) were given four hours orientation and agency Registered Practical Nurses (RPN's) were given two – four hours orientation working alongside the home's regular registered staff. Agency Personal Support Workers (PSW's) would come in an hour or two before their scheduled shift for orientation with the home's regular PSW's, if the agency PSW's were available to do so.

During an interview, the Acting Executive Director said they were aware that agency staff required orientation but it had not happened as the home had to ensure adequate staffing coverage to care for and meet the needs of the residents.

The licensee has failed to ensure that no person, including agency staff, performed their responsibilities before receiving training.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation [r.76 (4)] being issued in the home on April 17, 2014, in a CIS 2014_183135_0026 as a Written Notification. [s. 76. (2)] (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall ensure that falls prevention and management training shall be provided to all staff who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

During interviews with two identified Personal Support Workers they said they participated in an annual education day which reviewed a number of different topics. When asked if falls prevention and management was one of the programs reviewed and discussed they could not recall.

The Acting Director of Care told the Inspector that falls prevention and management was not a part of their annual education. Currently, for newly hired staff they review the orientation binder and staff sign off on the relevant policies. The acting Director of Care was unsure if falls prevention and management was a part of this orientation.

During a review of the orientation binder provided to the Inspector it was noted that there was no information related to falls prevention and management. The 2016 annual education schedule was also reviewed and there was nothing on the agenda regarding falls prevention and management.

The Physiotherapist told the Inspector that they had not provided education to staff regarding falls prevention and management. The Physiotherapist said that in the past they had conducted some in-services regarding safe lifting, ergonomics and falls prevention but the last time this was done was 2015.

The licensee failed to ensure that direct care staff were provided training in falls prevention and management.

The severity was determined to be a level a level one as there was minimum harm. The scope of this issue was widespread during the course of this inspection. There was compliance history of this legislation [r. 221(2)] issued September 14, 2015, in a RQI 2015_271532_0025 as a Voluntary Plan of Correction and [r. 221(1)1] issued May 5, 2014, in a CIS 2014_217137_0012 as a Voluntary Plan of Correction. [s. 221. (1) 1.] (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2017

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident 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.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that the restraint plan of care includes alternatives to restraining that are considered, and tried but have not been effective in addressing the risk.

Grounds / Motifs :

1. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried but have not been effective in addressing the risk.

The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried but have not been effective in addressing the risk.

An identified resident was seen with the physical device.

There was no documentation in the plan of care of an assessment related to the use of physical device/ restraint that included alternatives to the use of the physical device that were considered and tried, but had not been effective in addressing the risk.

During an interview with the lead for the restraints program RPN, they shared that the identified resident had a physical device applied for a long time. The Acting DOC told the Inspector that they were not able to find documentation as to the alternatives that were considered and tried for the identified resident prior to administering the restraint.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was pattern during this inspection. There was a compliance history of this legislation [r.31(3)] being issued in the home on September 7, 2016, in a RQI 2016_226192_0028 as a Voluntary Plan of Correction and issued on September 14, 2015, in a RQI 2015_271532_0025 as a Written Notification. [s. 31. (2) 2.] (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 07, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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.

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
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	**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

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 TORONTO, 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 27th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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