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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2018	2018_722630_0024	018595-18, 021340-18, 022258-18, 025084-18	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

AMIE GIBBS-WARD (630), ALI NASSER (523)

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 7, 8, 9, 13, 14, 15 and 16, 2018.

The following Complaint intakes were completed within this inspection:

Complaint Log #025084-18 / IL-59896-LO related to personal support services and plan of care.
Complaint Log #018595-18 / IL-58272-LO related to sufficient staffing.
Complaint Log #022258-18 / IL-59222-LO related to sufficient staffing.
Complaint Log #021340-18 / IL-59036-LO related to sufficient staffing and continence care.

Inspectors Christy Legouffe (730) and Meagan McGregor (721) were also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, the Scheduler, the Wound Care Lead Registered Practical Nurse (RPN), Registered Nurses (RN), RPNs, PSWs, family members and residents.

The inspectors also observed residents and the care provided to them, observed medication storage areas, observed medication administration, reviewed health care records and plans of care for identified residents, reviewed relevant policies and procedures of the home, reviewed the written staffing plan of the home, reviewed training records and reviewed written records of relevant program evaluations.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Sufficient Staffing

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

4 WN(s)
4 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).

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.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) infoline related to the application of specific assistive devices for an identified resident.

During multiple observations this identified resident was found not to have the specific assistive devices applied as per the plan of care.

The clinical record for this identified resident included the resident's requirement for these assistive devices and directions for staff regarding the daily application of these devices.

During an interview an identified staff member said that this resident required these assistive devices and they were to be applied by the nurses.

During an interview another identified staff member said they thought this resident required one specific assistive device and did not know that the resident required the other assistive devices. This staff member was not able to find the plan of care direction related to one of the devices.

During an interview the Director of Care (DOC) said that the home's expectation was for the care set out in the plan of care to be provided to the resident as specified in the plan of care. [s. 6. (7)] (523)

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

A. During an interview an identified staff member told Inspector #630 that an identified resident had compromised skin integrity and required assistance from staff with repositioning.

The clinical record for this resident included direction in the plan of care for continence care and repositioning. The PointClickCare (PCC) "Documentation Survey Report v2" for specific time periods had tasks related to the care for this resident which were not documented as completed. (630)

B. During an interview with an identified staff member they said that they found it difficult to provide the residents in the home with the care they required with toileting due to staffing levels but they did the best that they could. This staff member said that they documented the care they provided to residents in PCC and there were times when they were not able to complete all the required documentation on their shift related to not having enough time.

During an interview with another identified staff member they said they had been working in the home frequently short staffed and it seemed they were short staff more often than not for shifts. This staff member said they had troubles providing the assistance that these residents required and the timeliness of toileting, transferring and repositioning were affected. This staff member said that another identified resident required total assistance with care by staff including for continence care and repositioning.

The clinical record for this resident included direction in the plan of care for continence care and repositioning. The PointClickCare (PCC) "Documentation Survey Report v2" for specific time periods had tasks related to the care for this resident which were not documented as completed.

During an interview the ED told Inspectors #630 and #730 that it was the expectation in the home that the documentation of care provided to residents would be completed. The ED said that at times when they had been short staffed PSWs in the home that documenting the care provided was not always the priority and when the home was short staffed they would do the essentials of care.

Based on these interviews and record review the licensee has failed to ensure that the provision of care set out in the plan of care was documented. [s. 6. (9) 1.] (630)

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 and to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

Multiple complaints were received by the MOHLTC infoline related to the home not having a Registered Nurse (RN) who was an employee of the home and was present in the home at all times which impacted the residents' care.

A review of the RN staffing schedule showed the home had worked with no RN who was both an employee of the licensee and a member of the regular nursing staff of the home for 26.1 per cent of the RN shifts between August and November 14, 2018. The staffing schedule showed the following:
- For August 2018, the home worked with an agency RN for part of the shift to multiple shifts a day for 19/31 days for a total of 30 out of 93 shifts.
- For September 2018, the home worked with an agency RN for part of the shift to multiple shifts a day for 19/30 days for a total of 21 out of 90 shifts.
- For October 2018, the home worked with an agency RN for part of the shift to multiple shifts a day for 15/31 days for a total of 19 out of 93 shifts.
- For November 1-14, 2018, the home worked with agency RN for part of the shift to multiple shifts a day 11/14 days for a total of 13 out of 42 shifts.

During an interview the Executive Director (ED) said that they were aware of the RN shortages and that the home was using agency RNs to fill up vacant shifts. The ED said that they had ongoing effort and work with external agencies to recruit and hire RNs.

Based on these interviews and record reviews the licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times. [s. 8. (3)] (523)

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: 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).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Specifically the home did not comply with their written staffing plan titled "Daily Roster" to ensure that the assessed care and safety needs of the residents were being met and to promote continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident.

The home's written staffing plan titled "Daily Roster" indicated the following Personal Support Worker (PSW) staffing levels for 80 residents: 8 total per day shift; 8 total per evening shift; 3 total for night shift; total 19 per 24 hour period.

The home's "Contingency Staffing Plan" stated "we will make every effort to avoid staffing shortages." This plan also stated "staff should work together in a collaborative way to ensure that resident care is completed focusing on the essential tasks." The plan outlined the process for calling in staff, utilizing other departmental staff to assist with portering to meals and spotting for lifts, completing basic bed baths when short the PSW bath shift. The back-up plan did not define what tasks were considered essential versus non-essential that needed to be completed.

The ED provided a summary of the PSW staffing shortages for August, October and November 2018. These summaries showed the following staffing shortages:
- 29/570 (5 per cent) partial shifts short and 9/570 (1.5 per cent) full shifts short with 22/31 calendar days short at least one PSW for August 2018. The home utilized agency PSWs for 19/570 shifts (3.3 per cent) in August 2018.
- 28/570 (4.9 per cent) partial shifts short and 17/570 (3 per cent) full shifts short with 23/31 calendar days short at least one PSW for October 2018.
- 8/304 (2.6 per cent) partial shifts short and 5/304 (1.6 per cent) full shifts short with 11/16 calendar days short at least one PSW for October 2018.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint which identified a concern that residents were not receiving the care they required with continence care related to not having enough staff available in the home.

During an interview an identified resident told Inspectors #630 and #730 that residents had to wait for staff to assist them with continence care and at times that wait was between 30 to 45 minutes. This resident said that they required assistance from staff with continence care and has had to wait 30 to 45 minutes at times for help. When asked

if they had brought forward the concern to management in the home, this resident said that they had not as they did not think the staff could do anything about it.

During an interview with an identified staff member they said that they found it difficult to provide the residents in the home with the care they required with continence care but they did the best that they could do. This staff member said that residents deserved more care and that the residents should not have to wait 10 minutes or more to go the bathroom. This staff member said that it was difficult to provide the care residents required with morning care before breakfast was served. This staff member said that there had been times when they had been working short and that it was difficult to get the care done on those shifts. The staff member said that they would provide care but did not have enough time to complete the charting about all the care required.

The clinical record for this identified resident showed they required a specific type of assistance from staff with continence care. The PointClickCare (PCC) "Documentation Survey Report v2" for specific time periods showed specific tasks were not documented as completed.

During an interview an identified staff member said they had been working in the home frequently short staffed and it seemed they were short staff more often than not for shifts. This staff member said the home did have a back-up plan but it was not fully implemented especially when short multiple staff. They said that there were a lot of residents that required two staff assistance with transferring and toileting and it meant that the residents had to wait for care as they had to wait to find a second staff member to assist. This staff member said they had troubles providing the assistance that these residents required and the timeliness of toileting, transferring and repositioning were affected.

During an interview the ED told Inspectors #630 and #730 that the home had a written staffing plan which included the plan for registered nursing staff and PSW staff. The ED said that the plan stated that there were eight PSWs on the day and the evening shifts for the home and three PSWs for night. The ED said that they promoted consistency of care through having assigned full-time and part-time lines. When asked how they ensured that the written staffing plan was meeting the needs of the residents, the ED said they would compare to other homes, look at the needs of the residents based on feedback from residents, families and staff and that this had to be managed with the funding provided. The ED said that the home had shifts where they had been short PSW staff and that they have had to use the back-up plan. When asked if the home had been short

PSW staff most days the ED said that they had been despite ongoing efforts to hire and train new staff and to implement and attendance management program. The ED said that there were no indications that they knew of that the care was not being provided to the residents. The ED said that at times the management team, including the office manager, would go and help in the dining room or the ED would respond to call bells in the tub room if needed. The ED said it was the expectation that staff would be documenting the care provided to the residents. The ED said that documenting the care provided was not always the priority and when the home was short staffed they would do the essentials of care. The ED said that they continued to do their best regarding the staffing in the home with the resources available.

Based on these interviews and record reviews the home has failed to ensure that the written staffing plan of the home met the care and safety needs of residents related to regular PSW staff shortages. [s. 31. (3)] (630)

2. The licensee has failed to ensure that a written record relating to each evaluation under clause 31 (3) (e) was kept that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Executive Director (ED) provided Inspector #630 with the written record of the home's annual evaluation of the written staffing plan for personal support and nursing services in the home. This record was titled "2018 Human Resources (HR) Area: Staffing." This record did not include the date of the evaluation, the names of the persons who participated in the evaluation or a summary of the changes made. This record did not include a record of how the written staffing plan was evaluated and updated to ensure it was meeting the assessed care and safety needs of the residents in accordance with evidence-based practices.

During an interview the ED told Inspector #630 that the evaluation of the staffing plan was completed within the last few months and had been completed by the office manager and themself as there was a transition for the Director of Care (DOC) at the time. They acknowledged that the written record did not include the date or the names of the participants as well as the changes that had been implemented. The ED said that this had been their first annual evaluation of the staffing plan that they had completed since starting in their position in the home and they were starting from scratch. When asked if the evaluation included assessing how the staffing plan was meeting the care and safety needs of the resident, the ED said that they addressed that by focusing on

whether the staff were maintaining their competence, education provided to staff and a safe and healthy workplace. The ED said it was the expectation in the home that the annual evaluation would be completed in compliance with the legislative requirements. [s. 31. (4)] (630)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the staffing plan provides 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 and promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident and to ensure that the written record relating to each evaluation under clause 31 (3) (e) includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs that were stored in a medication cart that was secured and locked.

Observation on November 8, 2018 at 1202 hours, on the East wing hallway found an unlocked and unattended treatment cart with over 25 prescribed ointments and creams, dressing supplies, bottles of Antiseptic solutions, Disinfectant wipes, alcohol and other solutions. Inspector #523 and the Director of Care (DOC) observed the unlocked treatment cart together and the DOC said that the expectation was for all drugs to be secured and the carts locked when unattended.

Observation on November 15, 2018 at 1032 hours, on the south wing hallway found an unlocked and unattended treatment cart with over 14 prescribed ointments and creams, surface cleaners, wound care supplies, disinfectants wipes, and a bottle of Dovidine. Inspector #523 and the DOC observed the unlocked treatment cart together and the DOC said that the expectation was for all drugs to be secured and the carts locked when unattended.

Observations on November 15, 2018 at 1040 hours, on the east wing hallway found an unlocked and unattended treatment cart with over 25 prescribed treatment ointments and creams. Inspector #523 and the DOC observed the unlocked treatment cart together and the DOC said that the expectation was for all drugs to be secured and the carts locked when unattended.

Based on these observations and interviews the licensee has failed to ensure that drugs were stored in medication cart that was secured and locked. [s. 129. (1) (a) (ii)] (523)

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 stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

Issued on this 22nd day of November, 2018

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

Original report signed by the inspector.