Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2018	2017_624196_0020	024213-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
Office of the City Clerk 500 Donald St. East THUNDER BAY ON P7E 5V3

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

PIONEER RIDGE
750 TUNGSTEN STREET THUNDER BAY ON P7B 6R1

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

LAUREN TENHUNEN (196), JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 18 - 22, 2017.

The following intakes were inspected concurrently:

- one related to a complaint regarding resident care concerns;
- one related to a complaint regarding alleged staff to resident abuse;
- one related to a Critical Incident System (CIS) report submitted to the Director for an incident of alleged staff to resident abuse; and
- one related to a CIS regarding a resident injury with transfer to hospital.

The Inspectors also conducted a daily walk through of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed several resident health care records, and reviewed several licensee policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Clinical Managers, Best Practice Clinician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Registered Dietitian (RD), family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **6 WN(s)**
- **5 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	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.O. 2007, c.8, 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. (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. (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 there was a written plan of care for each resident that set out the planned care for the resident.

During observations of resident #002 on three separate dates, Inspector #625 observed the resident to have a device engaged when in their wheelchair.

A review of resident #002's current care plan and Treatment Administration Record (TAR) did not identify that a device was used by the resident.

During interviews with PSWs #112, #116, and #117, and RPNs #118 and #119, they stated to the Inspector that resident #002 used a device when in their wheelchair.

During an interview with Inspector #625, PSW #120 stated that resident #002 used a device when in their wheelchair and that it should have been listed in the resident's care

plan.

During interviews with Inspector #625, PSW #121 and RPN #122 stated that the resident used a device when in their wheelchair, that the use of the device should be listed in the resident’s care plan, but that it was not.

During an interview with Clinical Manager #102, they stated to the Inspector that resident #002’s care plan should have identified that the resident used a device when in their wheelchair. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During observations of resident #002 on two separate dates, Inspector #625 observed the resident's right bed rail in the transfer position and the left bed rail in the guard position.

A review of resident #002’s current care plan, with a focus on bed rails, identified that the resident required specific assistance of one to two staff for bed mobility, that both bed rails were to be, "down" when the resident was in bed, and that the resident used the bed rails to for bed mobility.

During interviews with Inspector #625, PSW #117 stated that resident #002 used both bed rails, when in bed, in the, “down” position (horizontal or guard position) for bed mobility but that staff had to cue the resident to use them.

During an interviews with PSW #120 they stated to Inspector #625 that resident #002 used both bed rails in horizontal [guard] position when in bed for bed mobility.

During an interview with RPN #119 they stated to Inspector #625 that resident #002 used both bed rails in horizontal [guard] position when in bed for a specific purpose.

During an interview with RPN #122, they stated to the Inspector that resident #002 used bed rails for bed mobility and that the resident could have an incident if the rails were not used.

During an interview with Inspector #625, Clinical Manager #102 stated that they

interpreted the care plan to mean that the bed rails were not in use when they were, "down", but that the staff put the bed rails up for the resident to use when they provided care to the resident, and then lowered the bed rails so they were out of the way when the resident was in bed. The Manager stated that the care plan was not clear with respect to the position of the side rails, and how they were to be used by the resident.

During an interview with Clinical Manager #107, they stated to the Inspector that the position of the bed rails when in use was not clear, and that staff needed to know if the bed rails should be positioned in the horizontal [guard] or vertical [transfer] positions. [s. 6. (1) (c)]

3. During observations of resident #005 on two separate dates, Inspector #625 observed the resident's left bed rail to be in transfer position. The resident's right bed rail was observed in the transfer position during one observation and not in use during the second observation.

A review of resident #005's current care plan with a focus on bed rail use, identified that the resident used bed rails for bed mobility and, for safety, the resident used two bed rails, "up at night time".

During interviews with PSWs #109 and #112, they stated to the Inspector that resident #005 used bed rails for bed mobility.

During an interview with Inspector #625, RPN #113 stated that resident #005 used bed rails for their safety so they couldn't roll out of bed and for bed mobility.

During an interview with Inspector #625, Clinical Manager #107 stated they acknowledged that the use of bed rails for resident #005 were not clear with respect to the position of the bed rails [transfer or guard positions] but should have been clear with respect to the positioning of the bed rails. [s. 6. (1) (c)]

4. During observations of resident #007 in bed on two separate dates, Inspector #625 observed the resident's bilateral bed rails to be in the guard position. On a third separate date, when the resident was not in their bed, the Inspector observed the right bed rail in guard position and the left in transfer position.

A review of resident #007's current care plan with a focus on bed rail use, identified that the resident used bed rails for safety.

During an interview with PSW #108, they stated to the Inspector that resident #007 used bed rails to keep them from rolling out of bed and that they were positioned in the, "down" position [guard position].

During an interview with PSW #109, they stated to the Inspector that resident #007 used two partial bed rails. They stated that the bed rails were used in the [guard] position because the care plan indicated the resident used them when in bed and, because the resident used a specific assistive device for transfers, they would not be in the [transfer] position as they were not used for the resident to get out of bed.

During an interview with RPN #110, they stated to the Inspector that resident #007 used bed rails for safety.

During an interview with Inspector #625, RPN #113 stated that resident #007 used two half rails bed rails for safety. The RPN acknowledged that the resident's care plan did not identify how the bed rails were to be used or positioned but that, since the resident used a specific assistive device, they would not use them to transfer.

During an interview with Inspector #625, Clinical Manager #107 acknowledged that resident #007's care plan did not identify how the bed rails were to be positioned or why they were used. In addition, they stated that the care plan did not provide clear direction to the staff on the use of the bed rails. [s. 6. (1) (c)]

5. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #196 observed an area of altered skin integrity on resident #003.

The health care records for resident #003 were reviewed by the Inspector. The physician's orders on a specific date in 2017, written by MD #125, noted a specific treatment for the area of altered skin integrity.

During an interview, RPN #123 confirmed to the Inspector that the the area of altered skin integrity did not have the specific treatment in place. In addition, the RPN, confirmed that the physician's orders regarding this specific treatment, had not been placed into the care plan or the Treatment Administration Record (TAR), and should have been.

During an interview with Clinical Manager #102, they confirmed to the Inspector that the care plan and the TAR had not been updated with the physician's order for the specific treatment and this should have been done. [s. 6. (7)]

6. 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 changed or the care set out in the plan was no longer necessary.

During the inspection, Inspector #621 reviewed the most recent Resident Assessment Instrument (RAI) – Minimum Data Set (MDS), relative to the previous assessment, which identified that resident #006 had a change in their continence in the previous 180 days.

Inspector #621 reviewed resident #006's health care record, including their continence and Activities of Daily Living (ADL) Assistance care plans, last revised on two dates in 2017, which documented that this resident used a specific type of continence product during the day, and a specific type of continence product on nights.

During an interview with PSWs #105 and #104, they reported to Inspector #621 that resident #006 had a change in their continence over the past several months. In recent weeks, a reassessment had been completed of this resident's continence care product needs, which resulted in resident #006 having a change in product. PSWs #105 and #104 identified that a par stock of this resident's continence care products were kept within their room.

During an observation of resident #006's room, Inspector #621 identified a par stock of a specific type of continence care products in this resident's room and there were no other specific type of continence products present.

During an interview with RPN #103, they reported to Inspector #621 that when there was a change in a resident's care needs, that PSW would notify the RPN staff of the change, and that RPN staff would document any required changes in the resident's plan of care, which included updates to the care plan. Together with the Inspector, RPN#103 reviewed resident #006's most current continence and ADL Assistance care plans, and confirmed that documented interventions identified that resident #006 required a specific type of continence product during the day and a different type of continence product at night. RPN #103 indicated that a par stock continence care products were kept in the resident's room, and on observation of resident #006's room, they confirmed to the

Inspector that there was a stock of a specific type of continence products present, but not the different type of continence products, as identified in this resident's care plan.

During an interview with Clinical Manager #102, they reported to Inspector #621 that it was their expectation that when a resident's care needs changed, and the care set out in the plan of care was no longer necessary, that RPN staff were to document the necessary changes in the plan of care, including resident care plans to reflect the current care needs. [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 that ensures there is a written plan of care for each resident that set out the planned care for the resident, and there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

The Long Term-Care Homes Act, 2007, s. 29 (1) (a) requires every licensee of a long-term care home to ensure that there was a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and Regulation.

A review of the licensee's policy "Least Restraint Policy and Use of PASD's [sic]" approved January 1994, date of revision "in review", identified that personal assistive services devices (PASDs) were any physical or mechanical devices used only to assist residents with routine activities of daily living and to promote and maintain safety and comfort needs. The policy indicated that:
- If staff considered the use of a physical device which had the potential to be a restraint or PASD, they were required to complete the Initial and Quarterly Restraint & PASD Assessment form, explore alternatives in collaboration with the interdisciplinary team and the resident or SDM, and document evidence of alternatives tried and/or considered, and the results.
- If a physical device was determined to be appropriate, the staff were to discuss the use and risks with the resident and/or SDM and obtain consent; and
- Once consent was obtained for the use of the device, staff were to determine if the device was a restraint or a PASD.

During observations of resident #005 on two separate dates, Inspector #625 observed the resident's left bed rail to be in the transfer position. The resident's right bed rail was observed in transfer position during one observation and not in use during the second observation.

During an interview with PSW #112, they stated to the Inspector that resident #005 used bed rails for bed mobility, that they could fall out of bed if the bed rails were in use but that they could not get out of bed when the bed rails were used.

During an interview with Inspector #625, RPN #113 stated that resident #005 used bed rails for their safety, that the resident could roll out of bed if the bed rails were not in use and that the resident could not get out of bed if the bed rails were used. The RPN also stated that the resident used the bed rails for bed mobility. The RPN acknowledged that there was no, "Initial Restraint and PASD Assessment" or other required documents related to the use of the bed rails in the resident's health care record.

During an interview with Inspector #625, Clinical Manager #107, stated that resident

#005 used the bed rails as a personal assistive safety device (PASD). The Manager stated that PASD use required the completion of the Initial Restraint and PASD Assessment and Consultation/Consent for Restraint/PASD Use documents as outlined in the home's policy, "Least Restraint Policy and Use of PASD's[sic]" approved January 1994, date of revision listed as, "in review". The Clinical Manager was not able to locate consent from the resident of substitute decision maker (SDM) in the resident's health care record, or completion of assessment forms to identify that alternatives were trialled and considered. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with, specifically the written policy to minimize the restraining of residents, to be implemented voluntarily.

WN #3: 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, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #196 observed an area of altered skin integrity on resident #003.

Inspector #196 reviewed the health care records for resident #003, specific to the treatment of the area of altered skin integrity. The electronic progress notes indicated that on a date in 2017, a treatment order had been started; a care plan was initiated and the area of altered skin integrity was to be evaluated weekly, on a specific day.

The Inspector reviewed the home's, "Skin Care and Wound Management Program - revised Oct. 15, 2017". The program indicated that, "each resident who exhibits skin breakdown and /or wounds shall be assessed each week or more frequently, if needed, by a member of the registered nursing staff." and, "All skin assessments are documented in the progress notes".

Inspector #196 conducted an interview with RN #106, and they reported that the type of altered skin integrity that resident #003 had, was not applicable to the homes' wound/skin assessment tool. According to RN #126, the home's wound/skin assessment tool was to

be used for a different type of altered skin integrity.

During an interview, Clinical Manager #102 reported to the Inspector that registered staff could use the homes' wound/skin assessment tool. They also reported that, an initial assessment of any impaired skin integrity was to be documented in the electronic progress notes, and at a minimum, a weekly skin and wound assessment was to be documented in the progress notes until the area had healed. In addition, they confirmed to the Inspector that for resident #003, an initial assessment of the area of the residents' altered skin integrity had not been documented, at the time it was first identified. They confirmed to the Inspector that weekly skin assessments were not documented over a two week time period, in 2017, and should have been. They also added, that registered staff should have made a progress note to indicate the treatment provided by MD #125 on a specific date. [s. 50. (2) (b) (iv)]

2. During the inspection, Inspector #196 observed an area of altered skin integrity on resident #002.

Inspector #196 reviewed resident #002's health care records. The progress notes did not have documentation of a skin assessment or reference regarding this area since approximately eight months previous, in 2017. In addition, the Treatment Administration Record (TAR) and the current care plan did not identify the area of altered skin integrity.

During an interview, Clinical Manager #102, acknowledged to the Inspector that resident #002 had an area of altered skin integrity. Clinical Manager #102 confirmed to the Inspector, that the progress notes did not reference the altered skin integrity; the current care plan and the TAR did not reference the altered skin integrity. They also reported that it was expected that staff were to document in the progress notes, the skin and wound assessments done. They would expect to see an initial assessment in the progress notes, and at minimum, weekly documentation until the wound was healed. [s. 50. (2) (b) (iv)]

3. During the inspection, Inspector #196 determined that resident #007 had an area of altered skin integrity.

Inspector #196 reviewed resident #007's health care records. The physician's orders dated for a particular date in 2017, included a specific treatment for the area of altered skin integrity. On a subsequent date, there were additional physician orders regarding treatment of the area of altered skin integrity. In addition, approximately a week later,

there were new orders regarding treatment for the area of altered skin integrity. The wound/skin assessment tool was last documented on a particular date in 2017. The progress notes were reviewed and had an initial assessment recorded on a specific date, regarding an area of altered skin integrity. Further weekly skin assessments were missing on two specific dates in 2017.

During an interview, RPN #127 reported to the Inspector that resident #007 had a area of altered skin integrity; confirmed the treatment was as in the physician's orders; and stated the wound/skin assessment tool that was to be completed every week, and that a progress note was to be done every time the treatment was provided.

During an interview, Clinical Manager #107 confirmed to the Inspector that staff were to, at minimum, complete a weekly wound assessment and document in the progress notes, and complete the wound/skin assessment tool, or both. In addition, they went on to confirm that between a two week time period in 2017, and on a specific date in 2017, a weekly wound assessment had not been documented and should have been. They further confirmed to the Inspector that the wound/skin assessment tool had not been completed since a particular date in 2017. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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. (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 shall ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: All assessment, reassessment and monitoring, including the resident's response.

During observations by Inspector #625 of resident #007 on three separate dates, resident #007 had a device engaged while in their wheelchair.

A review of resident #007's health care record included the current care plan, which indicated the resident used a device while up in their wheelchair with monitoring and assessment of the device as per the home's policy.

A review of the licensee's policy titled, "Least Restraint Policy and Use of PASD's [sic]", approved January 1994, date revised listed as, "in review" identified that:
- the RPN, or PSW as delegated, were to monitor the resident every hour while restrained and document their actions and the resident's responses on the Restraint Record.
- the RPN, or PSW as delegated, were to release the resident from a physical restraint and reposition the resident every two hours, and as necessary and document their actions and the resident's response on the Restraint Record.
- registered nursing staff were to reassess the resident's condition, and evaluate the effectiveness of the restraint every eight hours and at any other time when necessary based on the resident's condition or circumstance. The staff member was then to initial on the Treatment Administration Record (TAR) that the assessment had been completed.

A review of resident #007's Restraint Record for a particular month in 2017, identified

that the record had not been completed hourly for the duration of the shift on one of 19 night shifts (or 0.05 percent of night shifts); 13 out of 19 day shifts (or 68 per cent of day shifts); and on 14 out of 19 evening shifts (or 74 per cent of evening shifts).

A review of resident #007's TAR, identified that the TAR had not been signed, or had been signed as "8" to indicate the resident was sleeping, on 19 out of 93 shifts (or 20 per cent of the shifts) of the shifts in a particular month in 2017, and on 17 out of 59 shifts (or 28 per cent of the shifts) in the following month in 2017.

During an interview with PSW #108, they stated to the Inspector that resident #007 used a device as a restraint when in their wheelchair and that PSWs were to document on the Restraint Record every hour.

During an interview with PSW #109, they stated to the Inspector that resident #007 used a device as a restraint. The PSW acknowledged that the Restraint Record for a particular month in 2017 had numerous blank areas, including entire day shifts on three consecutive dates in that month in 2017, from 0730-1430 hours and entire evening shifts over a ten day period in that same month in 2017, from 1530-2230 hours.

During an interview with RPN # 110, they stated that resident #007 used a device as a restraint and that it's use would be signed for by registered nursing staff in the TAR.

During an interview with Inspector #625, Clinical Manager #107 stated that resident #007's Restraint Record should have been completed hourly and, for a particular month in 2017, there were a significant number of incomplete time frames. The Manager also stated that resident #007's TAR should have been signed by registered nursing staff every eight hours to indicate reassessment that the resident continued to require the restraint but that staff did not sign for the reassessment every eight hours and had, in some cases, coded that the resident was sleeping. [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 that ensures 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: All assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A review of the home's policy, "Medication Errors & Adverse Reactions", last reviewed March 2017, identified that registered nursing staff were to document in the progress notes immediate actions taken to assess and maintain the resident's health. The policy also identified that, when an error involved a resident, documentation on the resident's record must include the type of error, effects on the resident, doctor's order, treatment given to the resident and ongoing monitoring and the follow-up needed including

measures taken to rectify the error.

A review of the home's policy, "Resident Incident Reporting", revised December 2016, identified that all incidents were to be reported to the oncoming shifts for follow-up that included an assessment and documentation for at least the next three shifts on all incidents without injury.

Inspector #625 reviewed a Medication Incident Form for resident #014 dated in 2017. The form identified that staff did not administer medication for this resident on the date it was due, but did so the following day, when the omission was identified.

Inspector #625 reviewed resident #014's progress notes and identified one entry related to the medication incident, which identified that the incident had occurred. Immediate actions taken to assess and maintain the resident's health were not documented in any subsequent progress note.

During an interview with Clinical Manager #107, they stated to the Inspector that there was no documentation in the progress notes of the treatment, ongoing monitoring and follow-up needed [immediate actions taken to assess and maintain the resident's health], but that they should have been documented for three shifts after the initial entry as per the home's policies. [s. 135. (1) (a)]

2. Please see WN #5, finding 1. paragraph 2 and 3 for information regarding the review of the home's policy, "Medication Errors & Adverse Reactions".

Inspector #625 reviewed a Medication Incident Form for resident #015 in which the resident was ordered a specific medication but was administered a different medication.

Inspector #625 reviewed resident #015's progress notes and identified one entry that indicated the resident received the medication as ordered. There were no notes to indicate the medication incident involving the resident had occurred, or the immediate actions taken to assess and maintain the resident's health.

During an interview with Clinical Manager #107, they stated to the Inspector that there was no documentation in the progress notes of the medication incident, the treatment, ongoing monitoring and follow-up needed [immediate actions taken to assess and maintain the resident's health], but that they should have been documented for three shifts after the initial entry as per the home's policies. [s. 135. (1) (a)]

3. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident or the resident's substitute decision-maker (SDM).

A review of the home's policy, "Medication Errors & Adverse Reactions", last reviewed March 2017, identified that, when an error has had resident involvement, documentation was to occur on the resident record indicating that the SDM was notified.

Inspector #625 reviewed a Medication Incident Form for resident #014. The form identified that staff did not administer medication to the resident on the date it was due, but did so the following day, when the omission was identified.

Inspector #625 reviewed resident #014's progress notes and identified only one entry related to the medication incident, which identified that the incident had occurred. Notification of the incident to the resident or SDM was not identified in the progress notes, or on the Medication Incident Form.

During an interview with Clinical Manager #107, they stated to the Inspector that there was no documentation in the progress notes related to the notification of the resident's SDM, but that any notification should have been documented there as per the home's policies. [s. 135. (1) (b)]

4. Please see WN #5, finding 3. paragraph 2 for information regarding the review of the home's policy, "Medication Errors & Adverse Reactions".

Inspector #625 reviewed a Medication Incident Form for resident #015 in which the resident was ordered a specific medication but was administered a different medication.

Inspector #625 reviewed resident #015's progress notes and identified one entry that indicated the resident received the ordered medication. There were no notes to indicate the medication incident involving the resident had occurred, or that the resident or their SDM were notified.

During an interview with Clinical Manager #107, they stated to the Inspector that there was no documentation in the progress notes related to medication incident involving resident #015 or the notification of the resident's SDM, but that any notification should have been documented there as per the home's policies. [s. 135. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker (SDM), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On two consecutive dates, Inspector #196 observed resident #004's specialized wheelchair device, soiled with debris.

During an interview with PSW #114, they reported to the Inspector that ambulation aides were washed in the washer once per month. The PSW then provided a document with a schedule titled, "Wheelchair Cleaning 2017" which indicated resident #004's wheelchair was washed in a particular month in 2017.

During an interview with with PSW #115, they confirmed to the Inspector that resident #004's device on their specialized wheelchair were soiled and stated that sometimes it was hard to keep them clean with certain residents. They added that they would plan to have the chair cleaned by the night shift staff.

During an interview with Clinical Manager #102, they reported to the Inspector that staff followed a schedule where the ambulation aides were cleaned on the night shifts, at least monthly. They went on to say that some resident chairs may have required more frequent cleaning and if staff noticed a wheelchair that needed to be cleaned, they could spot wash it or have it done on the night shift. They confirmed to the Inspector that the expectation would be to have wheelchairs clean and free of debris. [s. 15. (2) (a)]

Issued on this 17th day of January, 2018

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

Original report signed by the inspector.