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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2017_575214_0001	000429-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 Overlea Blvd. TORONTO ON M4H 1P4

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

R. H. LAWSON EVENTIDE HOME
5050 JEPSON STREET NIAGARA FALLS ON L2E 1K5

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

CATHY FEDIASH (214), GILLIAN TRACEY (130), YULIYA FEDOTOVA (632)

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): January 9, 10, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 2017.

Please note: The following inspections were conducted simultaneously with this RQI:

-Critical Incident System Inspection #001418-16 related to responsive behaviours.
-Critical Incident System Inspection #016416-16 related to falls.
-Complaint Inspection #034615-16 and #035208-16 related to resident care and missing clothing.
-Complaint Inspection #034743-16 related to resident care; application of a restraint and weight loss.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Registered Dietitian (RD); Director of Environmental Services; registered staff; Personal Support Workers (PSW); President of Residents' Council; President of Family Council; residents and families. During the course of this inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; reviewed Critical Incident System (CIS) submission; observed residents and the administration of medications.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During an interview with resident #103 on an identified date in 2017, they verbalized their preference regarding the time they wished to go to bed at night and that at times, they are put to bed earlier.

A review of the resident's clinical record indicated that on admission a paper from titled,

"Resident Questionnaire" was completed. The questionnaire had identified the resident's sleep habits and their usual bedtime. A review of the resident's current written plan of care demonstrated that no focus was in place that identified the resident's sleep patterns and preferred time to go to bed at night.

An interview with the DOC confirmed that a written plan of care had not been in place that set out the planned care for the resident in respect to their sleep patterns and preferences. [s. 6. (1) (a)]

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

Resident #401 was admitted to the home on an identified date in 2016. An assessment completed on an identified date in 2016, indicated the resident required an identified safety intervention to be in place. The DOC confirmed this safety intervention was not added to the written plan of care.

The plan of care was not based on the assessed needs of the resident.

Please note: This non compliance was issued as a result of Critical Incident Inspection #001418-16, which was conducted concurrently with the RQI Inspection. [s. 6. (2)]

3. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / Substitute Decision Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #401 was admitted to the home on an identified date in 2016. On an identified date in 2016, the resident started exhibiting an identified symptom. The resident's physician ordered an identified test on a specified date in 2016 and results received two days later confirmed abnormal findings. The DOC confirmed the results of the identified test results were not shared with the resident's SDM.

The SDM had not been provided the opportunity to participate fully in the development and implementation of the plan of care.

Please note: This non compliance was issued as a result of Critical Incident Inspection #001418-16, which was conducted concurrently with the RQI Inspection. [s. 6. (5)]

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

Resident #401 was admitted to the home on an identified date in 2016. The admission standing order's for the resident directed staff to monitor a specified testing result twice daily for 14 days following admission.

A review of the Medication Administration Record (MAR) and interview with the DOC confirmed the specified test results had not been monitored twice daily on seven identified dates during the specified time period.

The care set out in the plan of care was not provided to the resident as specified in the plan.

Please note: This non compliance was issued as a result of Critical Incident Inspection #001418-16, which was conducted concurrently with the RQI Inspection. [s. 6. (7)]

5. The licensee 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 care set out in the plan was no longer necessary.

A) Review of resident #101's clinical record contained information that a specified intervention was to be used on their bed and had not contained any information about two other specified interventions which were currently used by the resident. The home's Job Report records provided by the Director of Environmental Services on an identified date in 2017, indicated that one of the specified interventions was put into place for the resident on an identified date in 2016. On an identified date in 2017, staff #026 indicated that resident #101 had two of the specified interventions in place and no longer had the third specified intervention in place. On a specified date in 2017, registered staff #033 and the RAI Coordinator confirmed that records in the resident's plan of care were not updated at the time when the resident's care needs changed.

B) Review of resident #200's clinical record contained information that a specified safety device was to be in place for the resident when they were using their identified mobility device. On two identified dates in 2017, it was observed that a different specified safety device was applied while the resident was using their identified mobility device. This was confirmed by staff #026. On an identified date in 2017, the DOC confirmed that the resident was to have an identified safety device in place and that the plan of care was not

updated by the home, when the resident's care needs changed.

C) A review of resident #106's Minimum Data Set (MDS) quarterly assessment dated on an identified date in 2016, indicated that the resident was coded as being incontinent of their bladder. A review of the corresponding narrative Resident Assessment Protocol (RAP) identified that the resident was unable to recognize or respond appropriately to bladder cues.

A review of the resident's RAP history for urinary incontinence indicated that the resident was no longer able to recognize or respond appropriately to bladder cues since their assessment dated on an identified date in 2015.

A review of the resident's written plan of care in place indicated that interventions to manage their urinary incontinence included a specified intervention regarding the importance of emptying their bladder completely. This intervention was created on an identified date in 2010. The plan also indicated that staff would use an identified intervention for urine control. This intervention was created on an identified date in 2012.

An interview with PSW staff #075 and #100 confirmed that the resident was no longer able to participate in the identified interventions and had not been able to for quite some time.

The DOC confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed. (Inspector #214) [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 is based on an assessment of the resident and the resident's needs and preferences; hat the care set out in the plan of care is provided to the resident as specified in the plan and 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 is no longer necessary, 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 failed to ensure that where the Act or this 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 was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with s. 8. (1) (b), that required a long term care home to ensure that there was an organized program of nursing services for the home to meet the assessed needs of the resident.

The home's policy titled Vital Signs, 9.05.10, revised November 15, 2007, indicated: TPR (temperature, pulse, respiration) and BP (blood pressure) were to be monitored on any resident exhibiting a change in condition.

According to progress notes, for a specified period of 20 days in 2016, resident #401 exhibited identified symptoms. During this time period the resident did not consistently have their TPRs monitored as per the home's policy.

The DOC confirmed the resident exhibited a change in condition and that resident #401 should have had their vital signs monitored where their condition warranted it.

Please note: This non compliance was issued as a result of Critical Incident Inspection #001418-16, which was conducted concurrently with the RQI Inspection. [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 to ensure that where the Act or this Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act and in accordance with s. 8. (1) (b), that require a long term care home to ensure that there is an organized program of nursing services for the home to meet the assessed needs of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home that included, at a minimum the following: any risks the resident may pose to himself for herself; the type and level of assistance required relating to activities of daily living; and known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

Resident #402 was admitted to the home on an identified date in 2016. At the time of admission the resident had an identified health history and required assistance with activities of daily living.

According to the 24 hour admission plan, there was no direction to staff providing care, regarding the level of assistance required by the resident for their specified activities of daily living. The DOC confirmed these areas were not identified on the written plan of care until 24 days after their admission.

The DOC also confirmed that a written plan of care to address any risks associated with a specified diagnoses was not care planned until 24 days following the resident's admission.

The 24-hour admission care plan was not developed for resident #402 within 24 hours of the resident's admission.

Please note: this non compliance was issued as a result of the following CI #016416, which was conducted concurrently with the RQI Inspection. [s. 24. (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 the 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home that includes, at a minimum the following: any risks the resident may pose to himself for herself; the type and level of assistance required relating to activities of daily living; and known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) An interview with the DOC confirmed that the home had not evaluated and updated their skin and wound care program in 2015.

B) An interview with the DOC confirmed that the home had not evaluated and updated their continence care and bowel management program in 2015. [s. 30. (1) 3.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A review of resident #103's current written plan of care indicated specified interventions to manage an identified care requirement that was to be completed a minimum of eight times per day. A review of the Point of Care (POC) documentation system for a specified period of three consecutive days in 2017, indicated that the specified interventions were documented as being completed one time on the first identified date of review, three times on the second identified date of review and three times on the third identified date of review.

An interview with PSW staff #040; #056 and #100 on an identified date in 2017, indicated that the resident's specified interventions were completed as required.

An interview with the DOC confirmed that all actions had not been documented on the identified dates reviewed.

B) A review of resident #101's current written plan of care indicated that they required assistance for a specified care need every two hours and as needed. A review of the POC documentation system was conducted on an identified date in 2017, which indicated that there was no documentation option available to document the actions taken for the specified care need. On an identified date in 2017, an interview with staff #026 confirmed that the resident had their specified care need provided as per their plan of care and that there were no tasks in the POC system to document their actions. On an identified date in 2017, the RAI Coordinator and the DOC confirmed that there was no task included in the POC system for the staff to document the action of the residents specified care need. (Inspector #632)

C) On an identified date in 2016, resident #400 alleged that resident #401entered their room and demonstrated an identified responsive behaviour toward them. The allegation was recorded in resident #400's clinical record; however, there was no information about the incident or follow-up to the incident recorded in resident #401's clinical record.

The DOC confirmed in an interview that not all actions taken with respect to resident

#401 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Please note: This non compliance was issued as a result of Critical Incident Inspection # 001418-16, which was conducted concurrently with the RQI Inspection. (Inspector #130).

D) A review of resident #105's current written plan of care indicated specified interventions to manage an identified care requirement that was to be completed a minimum of eight times per day. A review of the POC documentation system for a specified period of three consecutive days in 2017, indicated that the specified interventions had been documented as being completed twice on the first identified day of review, three times on the second identified day of review and three times on the third identified day of review.

An interview with PSW staff #025 on a specified date in 2017, indicated that the resident's indicated that the resident's specified interventions were completed as required.

An interview with the DOC confirmed that all actions had not been documented on the identified dates reviewed.

E) A review of resident #106's current written plan of care indicated specified interventions to manage an identified care requirement that was to be completed a minimum of seven times per day. A review of the POC documentation system for a specified period of three consecutive days in 2017, indicated that the specified interventions had been documented as being completed once on the first identified date of review, twice on the second identified date of review and three times on the third identified date of review.

An interview with PSW staff #025 on an identified date in 2017, indicated that the resident's specified interventions were completed as required.

An interview with the DOC confirmed that all actions had not been documented on the identified dates reviewed.

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 ensue that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over six months.

A) Resident #200 was identified with a specified nutritional risk level related to identified diagnosis. On an identified date in 2016, the resident's clinical record indicated that the resident sustained an identified change in their weight over a specified period of time. On an identified date in 2017, an interview with non-registered staff #002 indicated that registered staff on night shift would provide for non- registered staff the list of those

residents, who's weights or re-weights were to be completed if there was any identified weight changes. On an identified date in 2017, the RD indicated that night shift registered staff were to inform the RD about any confirmed weight change by e-mail for the need of a nutritional assessment. On an identified date in 2017, the DOC confirmed that any specified weight changes were to be cleared by the night shift registered staff in the form of requesting a re-weigh and, if confirmed, informing the RD for the need of the nutritional assessment and that these actions had not been completed.

B) Resident #100 was identified with a specified nutritional risk level related to identified diagnosis. On an identified date in 2016, the resident's clinical record indicated that the resident sustained an identified change in their weight over a specified period of time. On an identified date in 2017, an interview with non-registered staff #002 indicated that registered staff on night shift would provide for non- registered staff the list of those residents, who's weights or re-weights were to be completed if there was any identified weight changes. On an identified date in 2017, the RD indicated that night shift registered staff were to inform the RD about any confirmed weight change by e-mail for the need of a nutritional assessment. On an identified date in 2017, the DOC confirmed that any specified weight changes were to be cleared by the night shift registered staff in the form of requesting a re-weigh and, if confirmed, informing the RD for the need of the nutritional assessment and that these actions had not been completed.

C) Resident #101 was identified with a specified nutritional risk level related to identified diagnoses. On an identified date in 2016 and an identified date in 2017, the resident's clinical record indicated that the resident sustained an identified change in their weight over a specified period of time. On an identified date in 2017, an interview with non-registered staff #002 indicated that registered staff on night shift would provide for non-registered staff the list of those residents, who's weights or re-weights were to be completed if there were any identified weight changes. On an identified date in 2017, the RD indicated that night shift registered staff were to inform the RD about any confirmed weight change by e-mail for the need of the nutritional assessment. On an identified date in 2017, the DOC confirmed that any specified weight changes were to be cleared by the night shift registered staff in the form of requesting a re-weigh and, if confirmed, informing the RD for the need of the nutritional assessment and that these actions had not been completed.

D) Resident #107 was identified with a specified nutritional risk level related to identified diagnosis. On an identified date in 2016, the resident's clinical record indicated that the resident sustained an identified change in their weight over a specified period of time.

On an identified date in 2017, an interview with non-registered staff #002 indicated that registered staff on night shift would provide for non- registered staff the list of those residents, who's weights or re-weights were to be completed if there were any identified weight changes. On an identified date in 2017, the RD indicated that night shift registered staff were to inform the RD about any specified weight changes by e-mail for the need of the nutritional assessment. On an identified date in 2017, the DOC confirmed that any specified weight changes were to be cleared by the night shift registered staff in the form of requesting re-weigh and, if confirmed, informing the RD for the need of the nutritional assessment and that these actions had not been completed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of continence care and bowel management in accordance with O. Reg. 79/10, s. 221(1)3, in relation to the following: [76(7)6]

A) An interview with the DOC confirmed that the home had not provided annual retraining to any staff who provided direct care to the residents in the area of continence care and bowel management in 2015.

B) An interview with the DOC confirmed that the home had not provided annual retraining to any staff who provided direct care to the residents in the area of skin and wound care in 2015. [s. 76. (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 all staff who provide direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219 (1) in the area of continence care and bowel management in accordance with O. Reg. 79/10, s. 221(1)3, in relation to the following: [76(7)6], to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were 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.

A) During a tour of the home on an identified date in 2017, resident #300 was observed to be sitting in their identified mobility device with an identified safety device in place. The right side of the identified safety device was observed to have been applied incorrectly. An interview with PSW staff #069 confirmed that the identified safety device was applied incorrectly. The PSW staff undid the identified safety device and applied it correctly. A review of the manufacturer's directions for the application of the identified safety device indicated through picture diagrams that the safety device was not to be applied in the manner it was observed to be applied in. An interview with the DOC confirmed that the identified safety device was not applied correctly.

B) On an identified date in 2016, an identified person indicated that resident #200's identified safety device was not applied correctly while they were using their identified mobility device. A review of the identified safety device information, provided by the home, contained the information about correct application of the identified safety device and indicated that it was to be applied in a specified manner. On two identified dates in 2017, it was observed that the identified safety device was applied in a manner not consistent with the manufacturer's specifications. This was confirmed by staff # 026 on an identified date in 2017. [s. 110. (1) 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 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control program evaluated and updated at least annually in accordance with evidence-based practices, if there were none, in accordance with prevailing practices.

On an identified date in 2016, the DOC confirmed that the Infection Prevention and Control Program was not evaluated and updated at least annually in accordance with evidence-based practices, if there were none, in accordance with prevailing practices. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participated in the implementation of the program.

A) On two identified dates in 2017, three unlabeled tooth brushes were found on the counter top in residents' shared bathroom and three unlabeled black hair combs were found in tub rooms located on identified areas in the home. An interview with staff #025 and #055 identified that resident's personal items were to be labeled. On an identified date in 2016, an interview with the DOC confirmed that the personal items were to be labeled by using labels for personal items. The home's staff did not participate in the implementation of the Infection Prevention and Control Program.

B) On an identified date in 2016, a family member of resident #200 stated that they were not allowed to visit during an enteric outbreak declared in the home on an identified month in 2016. A review of visitor access section included in the home's enteric outbreak policy, number 9.06.31 (revised on December 6, 2016) stated that discontinuation of visitation was not recommended unless there was an order issued by the medical officer of health. On an identified date in 2017, the DOC indicated that visitors were not allowed in the facility during an outbreak, which was explained to the family members during admission interview. The DOC confirmed that visitor's should have been allowed to visit during this outbreak and that all staff did not participate in the implementation of the home's Infection Prevention and Control program. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During an observation of resident #107's room, there was one quarter bed rail identified on both sides of their bed. An interview with staff #028 confirmed that the bed rails were in their lowest position and not being used. It was observed and measured by the LTC (Long Term Care) Home Inspector that the top of the bed rails while in their lowest position, sat 3.5 inches above the mattress level. A review of the resident's plan of care did not contain information about the bed rails used by the resident. According to the interview conducted with the resident on an identified date in 2017 and a review of the Minimum Data Set (MDS) assessment, dated with an identified date in 2016, the resident was independent and did not require physical help. On an identified date in 2017, registered staff # 037 indicated that there was no clinical assessment for the bed rails, which was confirmed by the DOC. [s. 15. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids, such as dentures labelled within 48 hours of admission and of acquiring, in the case of new items.

On an identified date in 2016, an identified person indicated that resident #200 had lost an identified personal item in the home. A review of the plan of care for the resident contained the information that they were admitted to the home on an identified date in 2016, with the identified personal item. On an identified date in 2017, an interview with the DOC indicated that the home had a specified external program that included the labeling of the identified personal item. The DOC indicated that this program ended on an identified date in 2015, and as a result, the home has not labelled the identified personal item since this time. The DOC confirmed that resident #200's personal item was not labeled within 48 hours of admission. [s. 37. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: for those complaints that could not be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint should be provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complied with paragraph 3 should be provided as soon as possible in the circumstances.

On an identified date in 2016, a family member indicated that an identified personal item was missing in the home for resident #200 and that the family member contacted the staff about the lost personal item on an identified date in 2016. A review of the resident's clinical record for an identified date in 2016, contained the information about the identified lost personal item, which included the date when the verbal complaint was received by the registered staff. Further review of the progress notes contained the information completed by the DOC about communication sent to nursing staff to investigate further timelines about the missing personal item. Review of the complaints and concerns policy number 9.11.12 with a date of revision of November 22, 2007, contained the information about the complaint procedure, where the DOC would follow up if the problem had not been resolved. On an identified date in 2017, an interview with the DOC indicated that another communication note was sent to the staff on an identified date in 2017, inquiring about the status of the missing identified personal item but no follow up response was provided to the complainant for their complaint, which was not resolved within ten business days. [s. 101. (1) 2.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (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, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually 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. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system.

An interview with the DOC on an identified date in 2017, confirmed that the interdisciplinary team had not met to evaluate the effectiveness of the medication management system in the home in at least the last two years. [s. 116. (1)]

WN #13: 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 failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an interview with registered staff #071 on an identified date in 2017, it was confirmed and observed that routine controlled substance medication had been dispensed into a medication package that also contained non-controlled substance medication's and that the medication package was stored inside the medication cart in an area that was not a separate locked area.

An interview with the DOC confirmed that routine controlled substances were not stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.