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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_330573_0026	013529-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

ROSEBRIDGE MANOR
131 Roses Bridge Road R. R. #2 Jasper ON K0G 1G0

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

ANANDRAJ NATARAJAN (573), RUZICA SUBOTIC-HOWELL (548)

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): October 31, November 01, 02, 03, 04, 07 and 08, 2016.

One critical incident inspection related to log #027101-16 was conducted related to staff to resident alleged verbal abuse.

During the course of the inspection, the inspector(s) spoke with Residents, family members, the President of the Resident and Family Councils’, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), an Activity Aide, Physiotherapy Assistant, Maintenance Staff Person, the RAI Coordinator, the Environmental Services Manager (ESM), the Nutritional Care Manager, the Life enrichment Coordinator, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed a medication pass including medication room, observed recreation activities, observed exercise therapy classes, reviewed home's relevant policies, reviewed minutes for Family and Residents' Council and reviewed Resident Health Care records.

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
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, specifically related to fall prevention interventions.

Resident #006's health care record identifies that the resident is at risk for falls and has history of falls from the bed to floor. The written plan of care for fall prevention directed staff to ensure that resident #006's bed to be placed at the lowest position when the resident is in the bed.

On November 01 and 03, 2016, Inspector #573 observed resident #006 lying in the bed and the resident's bed was not placed at the lowest position. On November 03, 2016, Inspector spoke with PSW #108, who indicated that resident #006 is at risk of fall from bed to floor, the PSW #108 observed resident #006's bed in the presence of the inspector and agreed with the inspector that resident bed should be placed at the lowest position.

Resident #003's health care record identifies that the resident is at high risk for falls and has history of multiple falls. Resident #003's written plan of care in effect included the use of a wheel chair tab alarm as one of the fall prevention interventions.

On November 03 and 04, 2016, Inspector #573 observed resident #003 sitting in a wheel chair without any wheel chair tab alarm attached to the resident. On November 04, 2016, Inspector spoke with RN #105, who indicated that resident #003 is at high risk for falls and recently sustained a injury to specific body part. The RN #105 observed resident #003 in the presence of the inspector and indicated that staff members are supposed to apply the tab alarm for resident #003 while the resident is sitting in the wheel chair. The RN #105 further confirmed with Inspector #573 that the staff members did not apply the wheel chair tab alarm to the resident #003. [s. 6. (7)]

2. The resident #012's recent fall history includes an incident on a specified date where the resident had an unwitnessed fall at the entrance of the dining room. From the post fall assessment it was found that the wheel chair tab alarm was not on and the lap belt was not applied. The resident did not sustain injury.

The resident's #012 health care record was reviewed related to minimizing of restraints. The resident's written plan of care dated on a specified date specifies fall prevention interventions for a use of wheel chair tab alarm and lap belt while seated in the wheelchair, a bed alarm, bed to lowest level and fall mats at each side of the bed. The physician authorized the use of lap belt and the resident's SDM consented.

On November 08, 2016 the physiotherapy assistant indicated the physiotherapy fall prevention intervention included the resident #012 to ambulate three times a week and

the resident could mobilize with two person assistance with the use of a walker.

On November 08, 2016 in the presence of PSW #111 resident #012 was observed to be seated upright in a tilt wheelchair with a lap belt applied, with no wheel chair tab alarm. PSW #111 indicated that she was caring for the resident and the resident was to have a wheel chair tab alarm applied. The PSW left the resident for a break and the resident remained in the wheelchair without a tab alarm on while the inspector sought out a staff member to inform them that there was no wheel chair tab alarm. The situation was rectified immediately by the RAI coordinator. [s. 6. (7)]

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, specifically related to fall prevention interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The Licensee failed to ensure that all doors that residents do not have access to must be kept closed and locked.

On October 31, 2016 at approximately 1000 hours Inspector #548 observed the Soiled Utility door on East wing to be equipped with a door handle that was engaged (locked) however, the door was slightly ajar. There were no staff present in the vicinity of the room. It was noted that the soiled utility room was not equipped with a resident-staff communication and response (otherwise known as a call bell system).

On October 31, 2016 at 1500 hours Inspector #548 observed the Soiled Utility door on East wing to be slightly ajar. There were no staff present in the vicinity of the room.

On November 02, 2016 at 1430 hours Inspector #548 observed the Soiled Utility door on East wing to be slightly ajar. At the time of the observation a housekeeping staff member was down the hallway in a bathroom cleaning the floor with her back turned away from the soiled utility room door.

On November 02, 2016 during an interview the DOC indicated that the Soiled Utility room is to remain closed and locked at all times and is not to be accessed by residents. Upon her investigation she indicated that there was a mechanical issue with the door and would rectify the situation immediately. [s. 9. (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 all doors that resident do not have access to must be kept closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The Licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Inspector #573 observed that the privacy curtains in the shared resident rooms to be insufficient in providing privacy to residents. Specifically,

On a unidentified shared residents room –between Bed A and B, the privacy curtain does not close completely leaving a gap of approximately 15 inches between the wall and privacy curtain.
On a unidentified shared residents room –between Bed C and D, the privacy curtain does not close completely leaving a gap of approximately 15 inches between the wall and privacy curtain.
On a unidentified shared residents room –between Bed A and B, the privacy curtain does not close completely leaving a gap of approximately 15 inches between the wall and privacy curtain. Further it was observed that there was no privacy curtain for bed B at the widow side, leaving a gap of more than 45 inches between the wall and privacy curtain.
On a unidentified shared residents room –between Bed A and B, the privacy curtain does not close completely leaving a gap of approximately 17 inches between the wall and privacy curtain.

On November 04, 2016, Inspector #573 and the home's Environmental Service Manager (ESM) observed the above identified resident rooms privacy curtains. The ESM indicated to inspector that the home will conduct a complete audit regarding the privacy curtains and rectify the above privacy curtains issues in the shared resident rooms. [s. 13.]

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 every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide complete privacy, to be implemented voluntarily.

WN #4: 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 has been reassessed at least weekly by a member of the registered nursing staff as clinically indicated.

Resident #015 was admitted to the home on a specified date with uncompromised skin integrity. The health care record was reviewed related to the resident's altered skin integrity. The resident had been identified as high risk for altered skin integrity due to her/his poor nutritional status, incontinence and preference to stay in bed the majority of the time.

The home's skin and wound program includes the tracking of the inception and resolution of wounds, a clinically specific wound assessment tool, called Wound Tracker that is to be conducted weekly for all altered skin integrity, two wound care champions and outside consultations.

On a specified date in 2016 a progress note entry indicated that the resident presented with four open areas to a specific body part, the physician was made aware. The

dietitian recommended the resident receive a nutritional supplement three times a day. At the time of the inspection the resident had not received the nutritional supplement since three months from a specified month in 2016.

The Minimum Data Set (MDS) dated on a specified date in 2016 specifies that the resident had a stage two ulcer.

The resident's care plan dated on specific month in 2016 specifies wound management interventions to include the observation and documentation of the skin status, appearance, colour, wound healing, signs and symptoms of infection and wound size.

On November 04, 2016 during an interview with Inspector #548 the resident indicated that her/his preference was to stay in bed and that she/he was comfortable.

On November 07, 2016 during an interview the DOC indicated that altered skin integrity is defined as redden skin or open areas and the home had a specific wound assessment clinical tool that is to be completed on a weekly basis for all altered skin integrity. In addition, the DOC indicated that registered nursing staff were to document in the progress notes the status of the wound, their assessment findings, a need for a treatment change and any consultations.

The home's policy titled: Wound Assessment and Documentation, CS-14.5, dated September 2015 specifies that the assessment of a wound is to include: location, size, depth, colour of involved tissue, drainage and subjective symptoms of pain, itching.

Review of the health care record indicated that there are two completed wound assessments on two specific months in 2016 using the clinically specific tool. There a third wound assessment for a specific month in 2016 was absent of information regarding the pressure ulcer.

Progress note entries were reviewed for five specific months in 2016. There are four progress note entries regarding the wound.

Inspector #548 observed that it was recorded in the resident #015's progress notes on a specified date in 2016 that wound was presented however, for seven specific months in 2016 absent are weekly wound reassessments for the stage two ulcer for resident #015. Inspector #548 spoke with RN #103 and DOC, both did not comment as to why there were no weekly skin and wound assessments conducted using the clinically specific tool.

[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 to ensure that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment tool specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcome for residents.

Resident #015 was admitted to the home on a specified date with multiple diagnosis. At the time of this inspection resident required extensive physical assistance with her/his activities of daily living. The resident is followed by an interdisciplinary team and staff reported that the resident refused to take meal service in the dining room therefore tray service is provided for all meals.

On October 31, 2016 staff member #101 reported that resident #015 had a low BMI and was not receiving a nutrition supplement. The health care record was reviewed specific to the resident's nutrition. On a specified date the dietitian indicated on the Physician order form to increase a specific type of nutrition supplement.

After two months on a specified date in was documented in the progress notes that the registered dietitian specifies to continue with the nutrition supplement for three times a day as the resident is a High Nutrition Risk due to decreased intake, low BMI, and presents with a pressure ulcer to a specific area.

The electronic Medication Administration Recorded (eMAR) on a specified month in 2016 indicated that the resident was administered a specific type of nutrition supplement three times a day for five days in the beginning of the month. Subsequently, there is no other record of the supplement being administered during the remainder of the month.

The Physician Medication Review document authorized from for three specific months in 2016 is signed and dated by the physician. The physician order specifies that a specific type of nutrition supplement is to be administered three times a day.

On November 04, 2016 during an interview the DOC indicated that registered nursing staff lead the medication reconciliation by creating a complete and accurate list of all the medications the resident is taking. This information is provided to the physician who reviews the list and an order is obtained for continued or discontinued list of medications in addition to diet regimes. The medication reconciliation is faxed to the home's pharmacy provider who double checks for any discrepancies and processes the physician orders. The medication reconciliation form populates the electronic medication administration record (eMAR). The eMAR prompts registered nursing staff to administer the necessary drug and nutritional supplements for each individual resident.

On November 04, 2016 the resident's #015 eMARs for four specific months in 2016 were reviewed by RPN #100 with the Inspector #548 present. The RPN #100 indicated that she did not administer the prescribed nutrition supplement on two specific days in November 2016 while working.

At the time of the inspection the DOC indicated that the home's pharmacy provider system had not prompted the need to reconcile medications for several residents in the home therefore, there was no documentation of the medication review for resident #015 in addition to the absence of the nutritional supplement on the eMARs as of a specified date in 2016.

On November 04, 2016 the Administrator indicated that there must have been a system failure from the pharmacy provider on a specified month in 2016 as the eMAR system

would signal a warning that the supplement was not administered at the prescribed times.

The home was aware that resident #015 required the prescribed nutrition supplement which was recommended by the dietitian and ordered by the physician.

On November 04, 2016 during an interview the DOC informed the Inspector #548 from her investigation confirmed that the pharmacy provider had not processed the physician orders nor populated the resident eMARS as required. However, the cause for the absent nutritional supplement on a specified month in 2016 remained unexplained.

At the time of the inspection the home and pharmacy provider had not rectified the system failure. [s. 114. (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 ensue that the home shall develop an interdisciplinary medication management system that provides safe medication management for residents, to be implemented voluntarily.

WN #6: 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 drugs are secure and locked.

The following medications were observed to be left unattended and in the vicinity of residents.

On November 01, 2016 at 1030 hours Inspector #573 observed a specific prescription topical ointment on resident's #001 bed side table.

On November 02, 2016 at 1200 hours Inspector #573 observed a specific prescription topical ointment on resident's #001 bed side table.

On November 02, 2016 at 1157 hours Inspector #548 observed a container of a specific prescription topical cream for an unidentified resident that was left on top of a locked Treatment Administration Cart in the home's lobby. The home's lobby facing the great room and this is a room where resident's congregate and is accessible to family, visitors and others who enter the home. From 1157 to 1206 it was observed that a container of topical cream was left on top of a Treatment Administration Cart. During this period of time several residents mobilized in front of the cart on their own or with assistance of personal support workers. A family member walked in front of the cart and one resident sat in a chair across from the drug. In addition, several staff members: maintenance, dietary staff, personal support workers and other registered nursing staff walked past the cart where the medication remained unattended. The Inspector #548 sought out a registered staff member. On November 02, 2016 RPN #102 informed Inspector #548 that RN #103 was providing treatments to resident's that day and was currently on lunch break. When speaking with the Inspector, RN #103 indicated that she was aware that all medications were to be kept secure and locked within the cart at all times.

The home's policy: Medication Storage, Policy 3-4, page 1-4 dated 01/2014 specifies that medications are to be stored in the cart or designated area of the medication room.

On November 02, 2016 the DOC indicated all drugs are to be kept secure and locked in the home.

On November 03, 2016 Inspector #548 observed a specific prescription topical ointment on resident's #001 bed side table. On the same day during an interview PSW #104 she indicated that the ointment is left at the resident's bed side until a registered nursing staff member picks it up as a part of her rounds. [s. 129. (1) (a)]

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 drugs are kept secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The Licensee failed to ensure that at least quarterly, a documented reassessment of each resident's drug regime was conducted.

The home's process is to complete a reassessment of each resident's drug regime on a quarterly basis. The medication profile is reviewed and prepared by registered nursing staff, authorized by a physician on a document titled: Physician Medication Review and the form is faxed to the home's pharmacy provider. The pharmacy provider is to review the medication profile for its accuracy. Medication reconciliation is thereby conducted on a quarterly basis. The scheduled quarterly reassessment is based upon the resident's admission to the home.

Health care record reviews were conducted on November 04, 2016 and November 07,

2016 for resident's #007, #012 and #015.

Resident #007 was admitted to the home on a specified date in 2016 with an individualized medication profile. The scheduled quarterly reassessments would be August 2016 and November 2016. A quarterly reassessment was conducted on August 11, 2016. At the time of the inspection there is no record of the November reassessment.

On November 08, 2016 during an interview RPN #102 indicated the medication reconciliation should have been completed for the period of November 01, 2016 to January 31, 2017 as the physician was to have reviewed the medications for resident #007, during their visit.

On November 02, 2016 the Inspector #548 spoke with the Pharmacist who indicated that the pharmacy processes all medication reconciliation for each resident at the home. The pharmacist added that this information then populates each electronic Medication Administration Record (eMAR) prompting the registered nursing staff to administer medications. He acknowledged that there had been an interruption in the medication review process due to a change in employees.

Resident #012 was admitted to the home on a specified date in 2015. The first recorded quarterly reassessment of the resident's drug regime was May 2016. Absent are the November 2015 and February 2016 reassessments, as confirmed by the home.

Resident #015 was admitted to the home on a specified date in 2016 with an individualized medication profile. There is no documented review conducted in April 2016 nor July 2016, as confirmed by RPN #102.The first documented reassessment of the resident's drug profile on the Physician Medication Review is dated from October 1-December 31, 2016.

On November 07, 2016 during an interview the DOC confirmed that the required quarterly assessments were not conducted for resident's #012 and #015. The DOC and RPN #102 added, that each resident is on a scheduled quarterly review. The Administrator indicated that the eMAR would provide a prompt of any change/discontinuation in medications for residents. She added, that the prompt would have notified the registered nursing staff who in turn would have prepared a medication review for the physician and faxed it to the pharmacy. The DOC acknowledged that she had become aware that there are an additional eight residents who have not had a quarterly documented reassessment of their drug regimes due to the pharmacy system

error. [s. 134. (c)]

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 complete the quarterly documented reassessment of each resident's drug regime for resident's having been identified as missing a quarterly review, to be implemented voluntarily.

WN #8: 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 failed to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On November 04, 2016, Inspector #573 observed resident #003 sitting in wheelchair with a tab alarm equipment pull string metal clip, which was replaced with a paper clip. The wheel chair tab alarm equipment was used for resident's #003 as one of the fall prevention intervention.

The tab alarm (Personal Monitor) equipment featured a dome and string mechanism that was attached to the resident's garment. When an unassisted exit takes place, the dome is pulled from its magnetic socket and an alarm sounds. One end of the pull string is connected to a metal clip which is firmly secured and attached to the resident garment.

On November 04, 2016, Inspector #573 observed resident #003 wheelchair tab alarm in the presence of RN #105, the paper clip attached to the resident's garment is not firmly secured. The RN #105 indicated to inspector that the metal clip in the pull string might have been damaged, and further she indicated that she was not aware that the metal clip was replaced with a paper clip to attach to the cord.

On November 04, 2016, Inspector #573 spoke with the DOC in relation to resident #003's tab alarm, who indicated that it is unacceptable to modify or replace the tab alarm pull string metal clip with the paper clip. The DOC agreed with the inspector that any modification without manufacture approval will affect the compliance of the tab alarm equipment. Furthermore, the DOC indicated to inspector that when the tab alarm equipment metal clip was damaged, it is expected that the staff would notify registered nursing staff to replaced the disrepair equipment. [s. 15. (2) (c)]

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

Specifically failed to comply with the following:

s. 110. (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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure as per O.Reg79/10, s.110 (7) 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:

5. The person who applied the device and the time of application
6. All assessment, reassessment and monitoring, including the resident's response
7. Every release of the device and all repositioning.

The resident #012's health care record was reviewed related to minimizing of restraints. The resident's has a fall history and the resident's care plan specifies fall prevention interventions for a wheelchair tab alarm and lap belt while seated in the wheelchair, a bed alarm, bed to lowest level and fall mats at each side of the bed. A physician authorized the use of wheel chair lap belt and resident's SDM consented.

The home's policy titled Physical Restraints, CS-5.3, dated June 2014 specifies that a clinical record will provide the details of restraint use and is to include: resident response to the restraint, monitoring and reassessment.

The home's document titled: Restraint Form identifies the resident #012 to have a wheelchair seat belt restraint. The form has a legend prompting staff to document restraint application, removal, resident repositioning and resident response. Staff are to initial that the resident has been repositioned hourly. In addition, there is a column for registered nursing staff to initial their reassessment.

On November 08, 2016 during an interview the DOC indicated residents with restraints are monitored hourly by the PSWs and they are to document the application, release, repositioning and resident condition on the Restraint Form. She further indicated registered nursing staff are to reassess resident condition, response and the effectiveness of the restraint hourly and document once, every eight hours that this was completed in the column titled: Re-Assess.

On November 08, 2016 the DOC indicated that the resident's #012 usual routine is to be placed in the wheelchair for breakfast at approximately 0800 hours and remains in the wheelchair for the majority of the day until resident retires at approximately 2100 hours.

On November 04 and 08, 2016 the resident was observed to be seated in the tilt wheelchair with the lap belt applied. When inspector #548 requested resident #012 to undo the wheel chair lap belt, on both the occasions resident was unable to cognitively and physically undo the lap belt.

The resident's #012 Restraint Form dated November 2016 was reviewed from November 01 to 08, 2016. On November 04 and 07, 2016 there is no documentation from 0800 hours to 1500 hours of the application, release, repositioning and resident condition. In addition, there is no clinical record of the registered nursing staff reassessment, monitoring including the resident response from November 01 to 07, 2016 from 0800 hours to 2100 hours.

On November 08, 2016 RPN #102 indicated that registered staff are to monitor, reassess resident condition, response and the effectiveness of the restraining device however, due to competing demands the documentation is not completed. [s. 110. (7) 5.]

Issued on this 13th day of December, 2016

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

Original report signed by the inspector.