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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Feb 9, 2018	2018_420643_0001	011028-17	Resident Quality Inspection

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street NORTH YORK ON M2K 1E1

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

Seniors' Health Centre
2 Buchan Court NORTH YORK ON M2J 5A3

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

ADAM DICKEY (643), GORDANA KRSTEVSKA (600), NATASHA MILLETTE (686), SHIHANA RUMZI (604)

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): January 8-12, and 15-19, 2018.

The following critical incident intakes were inspected concurrently with the RQI:
Log #017135-17 related to prevention of abuse and neglect, and
Log #029085-16 related to falls prevention and management.

The following complaint intake was inspected concurrently with the RQI:
Log #013005-17 - related to prevention of abuse and neglect, falls prevention and management and continence care.

The following compliance order follow-up was inspected concurrently with the RQI:
Log #003270-17 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Registered Physiotherapist (PT), Pharmacists, Activation Coordinator, RAI Coordinator, Environmental Services Supervisor, Food Service Supervisor, personal support workers (PSW), housekeepers, maintenance aide, Residents' Council and Family Council Representatives, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' and Family Council(s) and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
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
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **10 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_413500_0009	604

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #013 was triggered in stage two through Minimum Data Set (MDS) Most Recent [MR] assessment for bedfast.

A review of resident #013's most recent MDS assessment revealed that bedfast all or most times was coded. A review of prior MDS assessments revealed that the resident had been coded as bedfast all or most times on each MDS assessment for the year preceding the most recent assessment.

A review of resident #013's Physician Order Forms revealed an order directing registered staff to keep pressure off areas of impaired skin integrity. No order was found indicating the resident was to be bedfast and no direction was found related to periods of rest in bed related offloading to assist with healing.

A review of the resident's written plan of care, and a current kardex did not reveal information indicating resident #013 was bedfast.

An interview conducted with resident #013 acknowledged they stayed in bed most of the day. The resident stated they were informed by the nursing staff that they needed to rest in bed to heal the areas of impaired skin integrity and only gets out of bed when going on a leave of absence from the home.

Interviews conducted with Personal Support Worker (PSW) #114, and Registered Practical Nurse (RPN) #112, acknowledged they provide care to resident #013. The PSW and RPN both indicated that the written plan of care is to consist of information relevant to a residents care needs including transfers and bed mobility. The PSW and RPN stated that resident #013 had been bedfast due to having identified areas of impaired skin integrity, and pressure is to be off loaded to aid in healing and as such was bedfast using an identified bed system. The PSW and RPN reviewed the current written plan of care and kardex, and both acknowledged that neither included information which indicated resident #013 was bedfast and no clear direction was provided to the staff.

Interviews conducted with Registered Nurse (RN) #115 and Acting Associate Director of Care (ADOC) #116 indicated staff in the home refer to the written plan of care and kardex to review information related to resident care needs. The RN and ADOC stated that if a resident is coded on MDS as being bedfast, the information is to be included in

the written plan of care indicating the care needs when the resident is bedfast. The RN and ADOC acknowledged that the current written plan of care and kardex did not provide information related to resident #013 being bedfast and did not provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding concerns of a family member of resident #004.

Review of resident #004's MDS assessment indicated the resident used incontinent products and was assisted with toileting by two staff. Review of the MDS assessment further revealed that resident #004 had memory problems and cognitive impairment.

Review of resident #004's written plan of care revealed that the resident required assistance with toileting. The goal was for the resident to be clean, dry and odor free. Interventions in place for this goal were:
- Two staff to use identified equipment to transfer resident on/off toilet and a third staff for assisting with hygiene after toileting due to identified responsive behaviours. Staff were to remain with resident throughout toileting process;
- Provide personal care twice daily (BID) and after each incontinent episode;
- Record voiding every shift;
- Type brief and size, staff to change; and
- Note any changes in amount, frequency, color or odor and report any abnormalities to Registered Staff.

Observations by the inspector of resident #004's toileting routine revealed the following:
- at an identified time and date, resident #004 was transferred to the toilet using the above mentioned identified transfer equipment and toileted;
- at an identified time and date resident #004 was in bed and PSW #120 was changing resident's incontinent product; and
- on an identified date during two periods of one and a half hours, resident #004 was not observed to be toileted.

Interview with PSW #120 revealed that they were not sure when to toilet the resident, that the resident would call when needing assistance or the PSW would go and toilet resident #004 whenever they had time.

Interview with RPN #112 confirmed there were no clear directions in the written plan of care for staff as for when to assist the resident with toleting.

Interview with RAI Coordinator #137 confirmed that the home's expectation is for the registered staff to conduct a clinical assessment of residents and review and revise the residents' written plan of care so that the plan clearly communicates to the PSW what care the residents need. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A complaint was submitted to the MOHLTC regarding concerns of a family member of resident #004.

Review of resident #004's written plan of care revealed that the resident had been assisted with toileting by two staff using physical assistance to transfer until an identified date, when the RN RAI Coordinator updated the resident's written plan of care directing two staff to use identified equipment to transfer the resident for toileting. The resident required a third staff member to provide care for hygiene due to identified responsive behaviours. Staff were to remain with resident throughout the toileting process.

Review of Resident #004's MDS assessment revealed that the resident #004 had limitation in range of motion, did not follow instructions for the standing balance test, and general ROM restrictions were present. Review of resident #004's assessment records failed to reveal an assessment of the resident transfer status when their physical condition changed.

Interview with PSW #120 revealed that resident #004 had been able to hold on to the handles of the care equipment and remain still while being assisted with toileting before, but was no longer able to fully participate with transferring. Further, the PSW stated that regardless of the level of resident #004's participation, they had been transferring the resident using the identified care equipment. The PSW also acknowledged that they had not communicated this change in resident #004's condition to the registered staff.

Interview with the PT and RAI Coordinator revealed the criteria for using the identified

equipment to transfer a resident were that the resident had to be able to follow directions, to have a good grip with upper extremities to support upper body and had to be able to straighten both legs to place two feet on the foot base and stay steady to support the lower part of the body.

Interview with the RAI coordinator revealed that the staff had not communicated if resident #004 had been able to use both hands and feet to support their upper and lower body, only communicating that it was difficult to assist the resident with toileting.

Interview with PT confirmed that they had not assessed the resident regarding transferring for toileting as the resident had not been referred by registered staff for assessment, and the staff had not communicated to the PT that they had difficulty transferring resident #004.

Interview with the DOC verified that the staff did not collaborate with each other in the assessment of the resident's ability to use standing lift for transfer to toilet. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

a. During stage two of the resident quality inspection (RQI) nutrition and hydration was triggered for resident #005 related to staff interview during stage one.

Review of the home's policy titled Monitoring of Resident Weights, policy number VII-G-20.80, revised April 2016, revealed that the registered staff were to ensure that a resident be re-weighed if there was a difference in resident weight of two Kilograms (Kg) from the previous month. The registered staff were directed to investigate potential causes of weight variance including a review of eating patterns, hospitalizations, symptoms and observations including fluid retention. Registered staff were instructed to complete monthly weight variance reports and respond to weight variances in the electronic documentation and refer to the Registered Dietitian (RD if necessary. The RD was instructed to assess residents with identified weight variances, audit the monthly variance report, evaluate and update the electronic record

Review of resident #005's health records revealed they had been admitted to the home with identified medical diagnoses. Resident #005's plan of care indicated they were at

moderate nutrition risk and required assistance from staff for feeding. Review of resident #005's weight history revealed significant weight losses in each month of an identified four month period.

In interviews, RN #129, RPN #112, RPN #113 and RPN #101 stated that it was the process in the home for residents to be weighed monthly by the PSW staff, input into the electronic record and in the case of a change in the resident recorded weight would be re-weighed to confirm the change in weight. RPN #113 stated that residents who have had a two kg change from the previous month weight to be re-weighed. RN #129, RPN #112, RPN #113 and RPN #101 stated that residents with significant weight changes should be referred to the Registered Dietitian (RD) for assessment. RN #129, RPN #112, RPN #113 and RPN #101 further stated that referrals to the RD are completed using the referral form under the assessment tab on PCC.

Review of the monthly weights form completed for November failed to reveal a re-weigh of resident #005's weight changes greater than 2Kg. Review of the assessment tab in PCC failed to reveal a referral for resident #005's significant weight changes. Review of resident #005's progress notes failed to reveal an assessment of the significant weight changes by the RD.

b. Due to identified noncompliance with O. Reg. 79/10, s. 69 related to resident #005, the sample of residents was expanded to include residents #009 and #014.

Review of resident #009's health records revealed they were admitted to the home with identified medical diagnoses. Resident #009's plan of care indicated they were at high nutrition risk due to poor intake, low body weight and required assistance from staff for feeding. Review of Resident #009's weight history revealed significant weight changes in each month over an identified three month period.

Review of the monthly weights form completed for the first identified month failed to reveal a re-weigh of resident #009's significant weight change greater than 2Kg. Review of resident #009's progress notes revealed a quarterly assessment was completed during the first identified month by RD #119 assessing Resident #009's significant weight change. There were no further progress notes documenting assessment of resident #009's subsequent weight loss in the second or third month of the above mentioned three month period. Review of assessment tab in PCC revealed no referrals were made to the RD regarding any of the above mentioned significant weight changes.

In an interview, RN #129 stated there had not been any referrals made to the RD regarding significant changes in resident #009's weight in the last five months. RN #129 further stated that resident #009 was having poor intakes and staff were discussing strategies frequently.

c. Review of resident #014's health records revealed they had been admitted to the home with identified medical diagnoses. Review of resident #014's care plan revealed they were at high nutrition risk and was fed via feeding tube. Resident #014 was found to have had a significant change in weight over an identified one month period.

Review of the monthly weights form completed for the above mentioned identified month failed to reveal a re-weigh of resident #014's weight change of greater than 2Kg. Review of assessments tab in PCC failed to reveal documented referral to the RD for resident #014's significant weight change over the identified one month period. Review of resident #014's progress notes failed to reveal an assessment of resident #104's identified significant weight change.

In an interview, RN #129 stated that no referrals were submitted to the RD regarding a significant weight change for resident #014. RN #129 further stated that a referral should have been communicated.

In an interview, RD #119 stated it was the process in the home for residents to be weighed each month and that it was the expectation that registered staff would complete a referral in PCC for residents with significant weight changes. RD #119 further stated that a weight variance report would be generated each month to further monitor resident weight changes. RD #119 acknowledged that no referrals were found nor assessment of significant weight changes of residents #005, #009 and #014 were completed.

In an interview, the DOC stated it was the expectation of the home for residents to be weighed at the beginning of each month and for any residents with a significant change to be re-weighed to confirm. Registered staff on the unit would then be required to assess if there was a reason for change in weight and refer to the RD for assessment. The DOC acknowledged that the staff and others involved in the different aspects of care of the residents failed to collaborate with each other in the assessment of the residents so that their assessments were integrated and were consistent with and complemented each other.

The severity of this issue was determined to be potential for actual harm to the

residents. The scope of this issue was identified as widespread as it related to three out of three residents inspected. Review of the home's compliance history revealed they had ongoing noncompliance with a voluntary plan of correction (VPC) issued. Previous non-compliance with this section of the LTCHA included:
- Voluntary plan of correction (VPC) issued on January 24, 2017, under inspection report 2016_413500_0009. [s. 6. (4) (a)]

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

During the medication observation preparation for resident #026, the inspector noted in the Physician Order Forms, the resident was started on a specified medication to be administered at an identified dosage and administration time. The physician had signed that he/she informed the family of the addition of the specified medication to the resident's drug regime. Over an identified one month period the dosage of the specified medication was changed four times.

Review of the Physician Order Form revealed an area to check off indicating family informed. On the initial order of the specified medication, the physician had initialed this area indicating they had informed the family. This was the only time that the area indicating family was informed had been initialed.

An interview was conducted with resident #026's SDM #147. who indicated they were to be contacted first. The SDM stated they were initially informed by the home's physician related to the addition of above mentioned specified medication, but was not contacted when there were subsequent changes to the dosage of the medication. The SDM stated as there were changes to the dosage of the medication there may have been concerns regarding effectiveness, and had expected to be kept informed of the resident's health status and changes to medication dosages.

In an interview, RPN #127 stated it was the home's expectation that when a change is made to the resident's medication the SDM is to be notified. The RPN stated when the family is informed the Physician Order Form includes an area to check off which indicates that the family was informed by the nurse or doctor that notified them of the change. RPN #127 additionally stated that nursing staff would document in a progress note indicating the SDM was informed of the changes to the medication. The RPN reviewed resident #026's Physician Order Forms for the identified one month period, and

stated the family informed area was not ticked off. The RPN reviewed the residents progress notes for the date range as indicated above and acknowledged that there was no evidence that the SDM was informed when the dosage of the specified medication was changed. [s. 6. (5)]

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

During stage two of the RQI, personal support services was triggered for resident #009 related to no notification of changes through family interview conducted during stage one.

Review of resident #009's medication review report for an identified quarter, revealed a physician order for a specified medication. Review of resident #009's physician order forms revealed an order one week prior to the end of the identified quarter, which decreased the dosage of the specified medication. The Physician order form did not show any marking in the box labeled "family informed". Review of resident #009's progress notes failed to reveal any notification or discussion with resident #009's family regarding this change.

Review of resident #009's medication review report for the following quarter, reflected the physician order for the specified medication at the specified reduced dosage. Review of resident #009's physician order forms revealed an order at the midpoint of the quarter, discontinuing the specified medication. The Physician order form did not show any marking in the box labeled "family informed". Review of resident #009's progress notes failed to reveal any notification or discussion with resident #009's family regarding this change.

In interviews, resident #009's family members #201 and #202 stated that the specified medication had been discussed with the physician during the previous care conference earlier in the year. Both family members #201 and #202 stated that they did not want to have the specified medication order for resident #009 changed as they felt that it was managing the resident's health condition. Both family members #201 and #202 stated that they were not notified or consulted when the medication dosage was decreased, nor were they notified or consulted when the medication was discontinued. Both family members #201 and #202 stated there had been a change in resident #009's health condition and found out the specified medication had been discontinued when resident

#009 had gone to hospital.

In an interview, RN #107 stated that when a medication or treatment order is changed, the change would be documented in the physician orders and registered staff were responsible for contacting family when signing off on the order. RN #107 further stated that this communication with a resident family member should be documented in the progress notes. RN #107 stated that a physician note was entered, indicating the physician was trying to ease back on some of resident #009's medications. RN #107 stated there was no documentation in the progress notes or physician order form that family was contacted. RN #107 further stated that there was no documentation to show that family was notified when the specified medication was discontinued. The RN acknowledged that resident #009's family was not involved in the care planning process with regards to medications.

In an interview, the DOC stated that the expectation of the home was for registered staff to discuss changes to a resident's medication or treatments with the resident, Substitute Decision Maker (SDM) or designate. The DOC stated that the registered staff would document the communication with family on the Physician Order Form in the family informed box, and/or in the progress notes. The DOC acknowledged that as resident #009's family had not been contacted regarding the decrease or discontinuance of the specified medication they were not given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

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

During stage two of the RQI personal support services - bedfast was triggered from the most recent MDS assessment data.

Observation conducted by the inspector on an identified date, revealed resident #011 was assisted by Personal Support Worker (PSW) #110 for personal hygiene, dressing, bed mobility, and toileting. PSW #110 independently provided assistance to the resident during the above mentioned care. When the resident was to be transferred from bed to a wheelchair, PSW #110 called a second PSW to assist with transferring resident #110.

Review of resident #011's MDS assessment indicated resident #011 was bedfast and needed total assistance by two staff for bed mobility, dressing, personal hygiene, and toileting. Review of the resident's written plan of care indicated resident #011 needed two

staff for bed mobility, toileting, personal hygiene, and dressing on days when resident #011 was to be transferred to their wheelchair.

Interview with PSW #109 and #120, and RPN #112 revealed that resident #011 was bedfast and needed total assistance by two staff for bed mobility, toileting, personal hygiene, and dressing on days when the resident is transferred to their wheelchair.

Interview with PSW #110 revealed that they provided care to resident #011. Further, the PSW confirmed that they always provided care to the resident alone and found it difficult to manage especially to reposition the resident in bed, providing personal care and dressing the resident. The PSW confirmed that they were aware that resident #011 needed two staff assistance but was not able to explain why they had provided care alone.

Interview with RPN #112 confirmed that the PSW did not provide care to the resident as specified in the plan of care.

Interview with DOC confirmed that the staff are expected to follow the direction from the written plan of care and provide care as specified in the plan. [s. 6. (7)]

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

During the family interview and resident observation in stage one, resident #010 was noted to have an identified skin condition which triggered for skin and wound in stage two.

A review of the current plan of care for resident #010, who was at risk for skin breakdown, was to have a specified position aide in place when up in the wheelchair.

An interview with SDM #149 identified concerns regarding resident #010's skin condition and interventions.

Observations by the inspector at an identified time and date revealed resident #010 sitting in their wheelchair at the dining room table. The above mentioned specified positioning aide was in place at the time of observation.

Observations by the inspector on another occasion revealed resident #010 sleeping in

their wheelchair in an identified common area. The above mentioned specified positioning aide was not observed to be in place.

In an interview, PSW #147, indicated they followed the residents care plan when proving care. The PSW indicated that resident #010 had interventions in place related to the prevention of impaired skin integrity. The PSW verified that the resident's SDM #149 brought specified positioning aide to the home and staff were to use it with the resident. PSW #147 indicated that it was in the resident's care plan to use specified positioning aide as that was what the SDM wanted. The PSW acknowledged that they had not placed the specified positioning aide for resident #010.

Observations by the inspector at an identified time and date revealed resident #010 sitting tilted in their wheelchair at their dining room table. The above mentioned specified positioning aide was not observed to be in place. Further observation revealed the resident sleeping in their wheelchair in an identified common area. The above mentioned specified positioning aide was not observed to be in place.

In an interview, RPN #102 indicated that staff followed the kardex when providing care and that the kardex is kept in the resident's charts. The RPN verified that it was identified in resident #010 care plan that staff were to ensure they used the specified positioning aide. The RPN acknowledged that the positioning aide was not in place. RPN #102 and PSW #147 both indicated that the specified positioning aide was used while resident #010 was in bed. The inspector verified with both the RPN and PSW that the resident's care plan indicated that the specified positioning aide was to be in place for resident #010 at all times, not only when in bed.

In an interview, RN #115 indicated that it was identified in resident #010's care plan that staff were to ensure that the positioning aide was always in place. The RN acknowledged that the positioning aide was not always observed to be in place at all times as specified in the resident's plan of care. [s. 6. (7)]

9. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care and have convenient and immediate access to it.

During stage two of the RQI, resident #011 was triggered for potential restraint from observation during stage one.

Observation by the inspector on an identified date, revealed identified care equipment was found engaged on resident #011's bed. After care was provided for resident #011 they were transferred to a specified type of wheelchair, positioned in an identified manner, a specified piece of care equipment was applied and the resident was moved outside the room.

Review of resident #011's specified assessment record indicated the resident was assessed for using the above mentioned type of wheelchair.

Review of resident #011's health record revealed a physician order and SDM consent for using only the above mentioned specified care equipment when resident was up in wheelchair for safety.

Review of the written plan of care for resident #011 did not include directions for the use of the specified equipment.

Interview with PSW #110 and PSW #122 indicated that they were not aware what was the content in the resident written plan of care for the specified equipment. Further, they both stated that they did not have time to read the resident's written plan of care and to keep aware of the contents of the plan of care.

Interview with RN #124 revealed that they were not aware of the content of resident' #011s plan of care. The RN was not able to identify the resident's assessments or to locate the information about the specified equipment in the resident's written plan of care. The RN was questioning why the specified type of wheelchair and care equipment were both applied at the same time. Further, RN #124 confirmed that they were not aware of the content of resident #011's written plan of care as they had many other residents to look after.

Interview with DOC confirmed that the staff are expected to keep self informed and aware of the contents of the plan of care when they provide care to the resident. [s. 6. (8)]

10. 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 care set out in the plan is no longer necessary.

During stage two of the RQI, resident #008 was triggered for incontinence from the most

recent MDS assessment.

Review of resident #008's MDS assessment revealed that the resident was assessed to have impaired continence status. Review of the resident’s continence assessment completed one month after the MDS assessment, revealed differing information regarding resident #008's continence status.

Interview with PSW #120 revealed that the resident was continent before but at some point in the last year had a change in condition. PSW #120 stated that resident #008 was now incontinent.

Review of resident #008's written plan of care revised three months after the above mentioned MDS assessment revealed that the resident was continent.

Interview with RPN #112 confirmed that resident #008's written plan of care had not been reviewed and revised since the resident's condition regarding continence had changed. The RPN stated that the registered staff was to assess the resident continence status when condition changed and review and revise the resident's plan of care. [s. 6. (10) (b)]

11. 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 care set out in the plan is no longer necessary.

Resident #013 was triggered in stage two through the most recent MDS assessment for bedfast.

A review of resident #013’s MDS assessment revealed bedfast all or most times was coded. A review of MDS assessments conducted quarterly revealed the resident had been coded bedfast all or most times each quarter over the year prior to the most recent assessment.

A review of resident #013’s written plans of care failed to reveal information indicating resident #013 was bedfast.

An interview conducted with resident #013 acknowledged they stayed in bed most of the day as they had areas of impaired skin integrity. The resident stated they were informed by the nursing staff that they needed to rest in bed to assist with healing of the above mentioned impaired skin integrity, and only got out of bed when going on a leave of

absence.

Interviews conducted with RPNs #115 and #123, indicated staff refer to the written plans of care for resident care information and the written plan of is reviewed and revised when the care needs of the resident change. The RPNs stated resident #013 was bedfast as they had areas of impaired skin integrity and were bedfast for the past six months for the purpose of aiding healing of the impaired skin integrity. The RPNs reviewed the written plans of care and acknowledged that the plan of care did not reflect resident #013's current bedfast status and the plan of care had not been revised.

In an interview, ADOC #116 stated the written plan of care provides staff with direction related to resident care needs and the plan of care is to be reviewed and revised when the resident care needs change. The ADOC reviewed resident #013's written plans of care and acknowledged that resident #013 was bedfast to aid in healing of impaired skin integrity and it was not reflected in the written plan of care and stated the plan of care had not been reviewed and revised. [s. 6. (10) (b)]

12. 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 care set out in the plan is no longer necessary.

During the family interview and resident observation in stage one, resident #010 was noted to have an identified skin condition which triggered for skin and wound in stage two.

A review of the current plan of care for resident #010, who was at risk for impaired skin integrity, was to have a specified positioning aide in place.

A review of resident #010's current kardex did not identify any interventions related to maintaining or improving skin integrity for the resident, nor did it identify that the resident was to have the above mentioned specified positioning aide in place.

An interview with SDM #149 identified concerns regarding resident #010's skin condition and interventions.

Observations by the inspector at an identified time and date revealed resident #010 sitting upright in their wheelchair at their dining room table. The above mentioned specified positioning aide was observed to be in place.

Observations by the inspector at an identified time and date revealed resident #010 sleeping in their wheelchair in an identified common area. The specified positioning aide was observed to not be in place at the time of the observation.

Observations by the inspector at an identified time and date revealed resident #010 sitting in their wheelchair at their dining room table. The specified positioning aide was not observed to be in place. Further observation revealed resident #010 sleeping in their wheelchair in an identified common area. The specified positioning aide was not observed to be in place.

In interviews, PSW #148 and PSW #147 indicated they followed the residents care plan when proving them with care. PSW #147 indicated that they located the resident's kardex and care plan in the electronic record or in the resident's chart.

In an interview, RPN #102 indicated that the PSWs followed the residents' kardex when providing them with care and that that information was kept in the resident charts.

In an interview, RN #115 indicated that the PSW staff primarily used the residents' kardex to provide them with direction for the resident's care needs. The RN verified that they could not identify anything in resident #010's kardex related to interventions for skin integrity, nor could they identify that the resident was to have the above mentioned specified positioning aide in place. RN #115 acknowledged that instruction should have been included in resident #010's kardex identifying interventions for skin integrity and identify the specified positioning aide to be in place. The RN indicated that they would update the kadex to reflect this.

In an interview, the DOC indicated that the PSWs have access to the residents care plan and kardex through point of care terminals, and that they should be referring to them when providing care to the residents. The DOC indicated that the PSWs refer primarily to the residents' kardex because it provides a brief summary of all resident care needs. The DOC indicated that the residents' kardex should be kept updated by staff when they enter new information into the residents' care plan. The DOC verified that they could not identify anything in resident #010's kardex related to interventions for skin integrity, nor could they identify that the resident was to have the specified positioning aide in place. The DOC acknowledged that there should be information related to skin integrity interventions and the specified positioning aide placement identified on the residents' kardex. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 with:
- ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident,
- ensuring 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,
- ensuring that the care set out in the plan of care is provided to residents as specified in the plan,
- ensuring that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, and
- ensuring that residents are reassessed and the plans of care reviewed and revised at least every six months and at any other time when, a goal in the plan is met, the resident's care needs change or care set out in the plan is no longer necessary, or care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 has 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:
- A change of 5 per cent of body weight, or more, over one month;
- A change of 7.5 per cent of body weight, or more, over three months; and
- A change of 10 per cent of body weight, or more, over 6 months.

a. During stage two of the RQI nutrition and hydration was triggered for resident #005 related to staff interview during stage one.

Review of resident #005's health records revealed they had been admitted to the home with identified medical diagnoses. Resident #005's plan of care indicated they were at moderate nutrition risk and required assistance from staff for feeding. Review of resident #005's weight history revealed the following significant weight changes over an identified four month period:
- A change of five per cent of body weight or more over one month;
- A change of 7.5 per cent of body weight, or more, over two months;
- A change of 7.5 per cent of body weight, or more, over three months; and
- A change of 10 per cent of body weight, or more, over four months.

In interviews, RN #129, RPN #112, RPN #113 and RPN #101 stated that it was the process in the home for residents to be weighed monthly and for residents with significant weight changes to be referred to the RD for assessment. RN #129, RPN #112, RPN #113 and RPN #101 further stated that referrals to the RD are completed using the referral form under the assessment tab on the electronic record.

Review of the assessment tab in the electronic record failed to reveal a referral for resident #005's significant weight changes. Review of resident #005's progress notes failed to reveal an assessment of the significant weight changes by the RD.

In an interview, RD #119 stated it was the process in the home for residents to be weighed each month and that it was the expectation that registered staff would complete a referral for residents with significant weight changes. RD #119 further stated that a weight variance report would be generated each month to further monitor resident weight changes. RD #119 acknowledged that no assessment of resident #005's significant weight changes was completed.

b. Due to identified noncompliance with O. Reg. 79/10, s. 69 related to resident #005, the sample of residents was expanded to include resident #009.

Review of resident #009's health records revealed they were admitted to the home with identified medical diagnoses. Resident #009's plan of care indicated they were at high nutrition risk and required assistance from staff for feeding. Review of Resident #009's weight history revealed the following significant weight changes over an identified three month period:
- A change of five per cent of body weight or more over one month;
- A change of 7.5 per cent of body weight, or more, over two months; and
- A change of 7.5 per cent of body weight, or more, over three months.

Review of resident #009's progress notes revealed a quarterly assessment was completed by RD #119 on an identified date, which included an assessment of the resident's significant weight change over the first identified month. There were no further progress notes documenting assessment of resident #009's subsequent weight changes in following two months. Review of assessment tab in the electronic record revealed no referrals were made to the RD regarding any of the above mentioned significant weight changes.

In an interview, RN # 129 stated there had not been any referrals made to the RD regarding significant changes in resident #009's weight since August. RN #129 further stated that resident #009 was having poor intakes and staff were discussing strategies frequently.

In an interview, RD #119 stated that resident #009 was already receiving nutrition interventions and and had been assessed on the above mentioned identified date. RD #119 acknowledged that no assessments of significant weight changes over the next two months were completed and that no referral was received to assess these changes in weight.

c. Due to identified noncompliance with O. Reg. 79/10, s. 69 related to resident #005, the sample of residents was expanded to include resident #014.

Review of resident #014's health records revealed they had been admitted to the home with identified medical diagnoses. Review of resident #014's care plan revealed they were at high nutrition risk and were on an enteral feeding regimen. Resident #014 was

found to have had a significant change in weight of five per cent of body weight or more over one identified month.

In an interview, RN #129 stated that no referrals had been submitted to the RD regarding a significant weight change for resident #014. RN #129 further stated that a referral should have been communicated.

Review of assessments tab in the electronic record failed to reveal a referral to the RD for resident #014's significant weight change over the identified one month period. Review of resident #014's progress notes failed to reveal an assessment of resident #014's significant weight change.

In an interview, RD #119 acknowledged that resident #014's significant weight change was not assessed as he/she had not received a referral. RD #119 stated they were not aware of the documented change in weight that month and that it was probably a measurement error.

In an interview, the DOC stated it was the expectation of the home for residents to be weighed at the beginning of each month and for any residents with a significant change to be re-weighed to confirm. Registered staff on the unit would then be required to assess if there was a reason for change in weight and refer to the RD for assessment. The DOC acknowledged that residents #005, #009 and #014 who had documented significant weight changes were not assessed using an interdisciplinary approach.

The severity of this issue was determined to be potential for actual harm to the residents. The scope of this issue was identified as widespread as it related to three out of three residents inspected. A review of the home's compliance history revealed that they had one or more unrelated noncompliance issued in the last three years. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Review of the home's License information indicated there were 192 licensed long-term care beds in the home. Based on 192 beds, the licensee is required to ensure that an RD is on site at the home for 96 hours per month, to carry out clinical and nutrition care duties. Review of hours logged by RD #119 and RD #152 revealed the following monthly hours:
- December 2017, RD #119 was on site for 76.5 hours, RD #152 was on site 6.5 hours for a total of 83 hours;
- November 2017, RD #119 was on site for 95 hours;
- October 2017, RD #119 was on site for 90.5 hours; and
- September 2017, RD #119 was on site for 80.5 hours, RD #152 was on site for 12.5 hours for a total of 93 hours.

In an interview, RD #119 stated that they were one of two RDs who has been working in the home over the past year. RD #119 stated that they had been working Mondays and Thursdays each week and covering all clinical and nutrition care duties for all residents in the home. RD #119 stated that RD #152 was working on a casual basis and had covered some hours in December while RD #119 was away. RD #119 stated that they had been working longer days of 10 to 11 hours in order to cover all the clinical and nutrition care duties and has been working approximately 40 hours bi-weekly. RD #119 was aware that the required hours for a RD on site at the home was 96 hours per month.

In an interview, Food Services Supervisor (FSS) #103 stated that it was the expectation of the home that based on 192 beds a RD should be on site to carry out clinical and nutrition care duties for 96 hours based on 30 minutes per resident per month. FSS #103 further stated that RD #119 was on site two days per week and was working longer

hours of 10 to 11 hours each day on site. FSS #103 stated that RD #119 was working between 88 and 94 hours per month. FSS #103 further stated that RD #152 was filling in for some hours on a casual basis and a position was currently posted for a casual part time RD which had not been filled.

In an interview, the administrator stated that it was the expectation of the home for a RD to be on site for 30 minutes per resident per month. The administrator acknowledged that the licensee had failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The severity of this issue was determined to be potential for actual harm to the residents. The scope of this issue was identified as widespread, as it had the potential to affect all residents in the home. The home had a level two compliance history as they had one or more unrelated noncompliance issues in the last three years. [s. 74. (2)]

Additional Required Actions:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and kept closed and locked when not supervised by staff.

Observations by the inspector during the initial tour of the home revealed a shower room door unlocked on an identified resident home area. The inspector brought it to the attention of PSW #146 who verified that that the door was not locked. The PSW indicated that the shower room door was not locking and had been reported to maintenance two weeks ago. The PSW indicated that shower room should be locked and that they would inform the RPN.

Observations by the inspector during the initial tour of the home revealed a storage room door unlocked on an identified resident home area. A sign was posted on the storage room door, which indicated please lock when not in use. There were no staff in attendance. The inspector brought it to the attention of RN #115 who verified that that the door was unlocked. The RN obtained the key and locked the room. The RN indicated that the door should have been locked.

On two identified dates the inspector observed the above mentioned shower room door not latched properly and unlocked. On two identified dates the inspector observed the identified storage room door unlocked and no staff in attendance.

In an interview, maintenance staff #144 stated they had received a requisition to fix the identified shower room door. The facility technician verified that they had fixed the shower room door the previous day.

In an interview, Environmental Services Supervisor (ESS) #136 verified that the identified shower room door had not been locking properly and had now been fixed. The ESS indicated that staff had been verbally reporting the shower door not locking on and off for a while. The ESS reviewed the electronic maintenance tracking system and verified that no requisition had been put in for the door not closing or locking properly at any time over the previous nine months. The ESS indicated the expectation is that staff will submit a referral in the electronic maintenance tracking system when doors are noted to require repair. [s. 9. (1) 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 with ensuring that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas, and those doors are kept closed and locked when not supervised by staff, to be implemented voluntarily.

WN #5: 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 had failed to ensure that when bed rails were used the resident had been assessed and had his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Observations by the inspector on an identified date revealed a specified type of bed rail engaged on resident #010's bed. On two subsequent observations, the above mentioned specified type of bed rail was observed to be engaged on resident #010's bed. On two other subsequent observations, two bed rails of a specified type were observed to be engaged on resident #010's bed.

A review of resident #010's bed safety assessment dated from an identified date

indicated that the assessment remained in progress and had not been locked. The assessment indicated that the resident was not using bed rails and did not require bed rails.

A review of resident #010's progress notes revealed an entry from the same date as the bed safety assessment, which identified that the resident's SDM #149 was in agreement to the removal of the bed rails.

In interviews, PSW #147 and PSW #148, both verified that resident #010 had two specified bed rails engaged and indicated that it was at the request of the resident's SDM. Both PSW #147 and #148 indicated the resident did not use the bed rails for mobility and required two staff to reposition at all times.

In an interview, RN #115 indicated that the home's process for assessing the need for bed rails for a resident was done through the bed safety assessment. The RN verified that a bed safety assessment had been initiated for resident #010 and remained in progress. RN #115 verified that the assessment indicated that bed rails were not needed for the resident. The RN verified the progress note related to a discussion with family member #149 about bed rails and that they were in agreement for them to be removed. The RN acknowledged that there was a discrepancy as the resident still had the bed rails on their bed.

A review the home's policy titled Bed Safety Program Overview, policy number VII-E-10.18(a), revised May 2017, indicated that based upon resident needs, the Physiotherapy/Occupational therapy, Nursing, and other members of the interdisciplinary team would assess the resident if the rationale for the consideration of bed rails was for mobility and transfer. If for any reason the resident or SDM refused to eliminate rails, an assessment would be done quarterly.

In an interview, the DOC indicated that the home determines if a resident is to have bed rails applied to their bed through the bed safety assessment. The DOC verified that a bed safety assessment had been initiated for resident #010, remained in progress and that it was incomplete. The DOC acknowledged that the bed safety assessment should have been completed. The DOC verified that the assessment indicated that resident #010 does not need bed rails. DOC #128 verified that the progress notes indicated that SDM #149 was in agreement to have the bed rails to be removed. The inspector stated that they had observed the bed rails engaged and that when staff were interviewed, they indicated that the resident's family member wanted the bed rails on the bed. The DOC

acknowledged that there were inconsistencies in how the home managed the assessment of bed rails for resident #010. [s. 15. (1) (a)]

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

During stage two of the RQI, resident #011 was triggered for potential side rail restraint through resident observation in stage one.

Review of resident #011's assessment record failed to reveal that the resident had been assessed for using bed rails. Review of the resident's written plan of care also failed to reveal that there was a plan to use two specified type bed rails for resident #011.

Interview with PT #134 revealed that resident #011 was not participating in the physio program since returning from the hospital when he/she was recommended to be bedfast, and the PT did not receive a referral to assess resident #011 for using bed rails.

Interview with RN #124 confirmed that two specified type bed rails were used for resident #011, but the resident had not been assessed. Interview with the RAI Coordinator confirmed that the resident is using a specified bed system and the specified side rails are applied with that type of bed system.

Interview with DOC indicated that where staff is using bed rails, the resident should be assessed and the bed system evaluated. Further the DOC confirmed that resident #011 should have been assessed for the use of bed rails, regardless of why they are applied. [s. 15. (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 with ensuring that when bed rails are used residents are assessed and bed systems are evaluated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were free from neglect by the licensee or staff in the home.

Neglect as outlined in section 2. (1) of the Regulation (O.Reg.79/10) means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint and CIR were submitted to the MOHLTC, regarding family concern about resident #004's safety and the care provided. Review of the complaint revealed that on an identified date, when visiting resident #004, family noted identified injuries to the resident. The complaint further revealed that one of the family members asked the nurses what had happened to resident #004, and the nurses could not provide them with a clear explanation. Further, the complaint review revealed that on an identified date the following month, again the family visited resident #004 who had a new identified injury. In both cases the family was not notified about the origin of the injury, or how the resident might have sustained the injuries. Review of the complaint also revealed that on an

identified date, a nurse reported to the family that resident had another identified injury four days following the first injury, which was likely from the wheelchair.

Review of resident #004's progress notes revealed on the first above mentioned identified date, RPN #157 documented an injury to a specified area of resident #004's upper body. Further, the RPN documented that the resident had not complained of discomfort, and as per PSW #120, the resident did not have the injury the day before and to continue to monitor the resident. The progress notes failed to reveal an investigation was conducted to identify how the resident sustained the injury. Further review failed to reveal if the resident was monitored and condition documented for the next two days, when a physician assessed the resident and ordered an x-ray.

Review of resident #004's assessment record failed to reveal an assessment was conducted on the above mentioned identified date, after an injury was identified. Review of PSW documentation record under skin observation failed to reveal that on the PSWs from any of the three shifts observed the resident's injury.

Interview with PSWs #120, #114 and #117 revealed that they had no recollection of the injury sustained by resident #004 on the identified date, and they were not sure if it had been reported to the nurse. Interview with the RPN #156, revealed that they did not recall anything about what happened on the identified date.

Interview with the family member who discovered resident #004's injury on the identified date, revealed that the staff were not able to explain how the the injury happened, and why the family were not notified. The family member reported the concern to the Administrator. Further, the family member revealed that four days later, they had received a voicemail from RPN #157 that resident #004 sustained an unrelated injury. The following month, while visiting, the family member noted signs of incontinence, and had to approach staff twice to change the resident who was becoming restless. The family member again complained to the manager who told them that they would investigate their concerns. The family did not hear from the home until the home scheduled a meeting with the family five days after the complaint regarding incontinence. When the family arrived, they noted resident #004 had a new injury. During the meeting the family did not receive any information about the bruises that the resident sustained, or if the home had conducted or planned to conduct an investigation. On the same date after the meeting, the home called the family for clarification if they considered this an alleged abuse. After the family confirmed, the home told them that they would conduct an internal investigation.

Interview with ADOC #138 confirmed that the RPN was expected to immediately report the the injury to the RN in charge, assess the resident considering a possible fall, assess the skin integrity, pain, and place the resident on head injury routine for 72 hours to monitor and document the resident's condition. The ADOC confirmed that the staff failed to provide proper treatment to the resident after the resident was noted to have an injury.

Interview with the DOC confirmed that the Registered Staff are expected to assess immediately any resident who had sustained an injury with unknown cause, to report to the RN and to document resident monitoring. Further the DOC confirmed that any bruise should be investigated and the family should be notified. [s. 19. (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 with ensuring that residents are free from neglect by the license or staff of the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage two of the RQI, resident #011 was triggered for potential side rail restraint from observation during stage one. Observation by the inspector, during resident's care

revealed that staff used specified bed rails, a specified trunk restraint and type of wheelchair for resident #011.

Interview with PSW #110 indicated that resident had restraints in place, using an identified type of wheelchair and trunk restraint when up in their wheelchair. Resident #011 additionally had two specified type bed rails for safety.

Review of the home's policy titled Restraint Implementation Protocols, policy number VII-E-10.00, revised November 2015, instructed Registered staff to do the following:
- obtain a written physician's or nurse practitioner's order for restraint usage to include purpose, type, and when the restraint is to be used,
- obtain a written consent for the initial restraint use, annually thereafter, and upon any changes to the restraint order,
- update the resident written plan of care, and
- evaluate quarterly and at any other time when a restraint is no longer required based on the resident condition or circumstances, using a Restraint/ PASD electronic assessment form.

The Policy instructed PSW or designates to:
- Review the resident's written plan of care and follow the recommended interventions, and
- Visually check the resident every hour for safety and comfort and document on restraint record.

Review of resident #011 health records with regards to using bed rails as a restraint and using the identified function on their wheelchair as a restraint revealed the following:
- no bed rails assessment conducted,
- no physician's or nurse practitioner's order,
- no consent provided,
- no updates in written plan of care,
- no quarterly evaluation, and
- no documentation for visual check every hour for safety and comfort.

Review of resident #011's health records also failed to reveal a restraint/PASD assessment conducted for using the identified trunk restraint.

Interview with RN #124 revealed that the resident had a restraint but some of them may not be needed so that is why they were not in the written plan of care, or did not have

doctor's order or family consent, or quarterly review.

Interview with DOC indicated the staff were expected to follow the policies of the home and acknowledged that the staff did not comply with the policy to minimize restraining of residents regarding the devices used for this resident. [s. 29. (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 with ensuring that the required written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A complaint and CIR were submitted to the MOHLTC regarding care concerns and unknown injuries of resident #004. Review of the complaint revealed that the family expressed their concerns regarding the care of resident #004 as the resident was found with an increased number of unexplained injuries.

Review of resident's health records revealed that resident #004 was admitted to the home with identified medical diagnoses. Resident #004 exhibited specified responsive behaviours and had difficulty communicating with staff. Review of resident #004's MDS assessment revealed they had cognitive impairment with memory problems and were not able to attempt test for standing balance without physical help. Resident needed two staff extensive assistance for transfer. Resident #004's plan of care revealed the resident required total assistance using a specified lift for toilet use.

Observation by the inspector of resident #004 transfer for toileting revealed the following concerns:
- the staff did not verify the resident was able to follow direction,
- resident was not guided or assisted to have both hands on the handles;
- the sling was not applied in the proper position,
- resident's lower extremeties were not positioned correctly,
- both feet were on one foot rest with legs overlapping, and
- when raising the resident they were hanging from the sling as they were not able to weight bear, and were observed moaning and crying during the transfer.

Review of the home's policy titled Resident Transfer and Lift Procedures, policy number VII–G-20.20, revised May 2017, revealed that PSW staff were expected to verify that the resident can use a sit/stand lift, check prior to moving a resident if they are able to follow simple commands, apply the sling with the upper border below the breast, assist the resident to place their feet on the footplates, ask the resident to grasp the handles on the boom, ask the resident to lean back slightly before lifting the resident.

Interview with the PT confirmed that the criteria for resident to be able to use the specified lift are that the resident must be able to participate and to follow simple direction, to be able to place both hands on the handle to support the upper body, the knees should be straight up as much as possible, both feet apart, flat on the footrest to support the lower part of the body.

Interview with PSW #120 revealed that they always transfer resident #004 in this manner, and were trying to assist the resident quickly to avoid them becoming agitated.

Interview with PSW #114 who was the second staff transferring the resident confirmed that the resident was not properly transferred when using the lift. PSW #114 was able to describe how the proper transfer should be done, however was not able to explain why they did not use safe transferring techniques when assisting resident #004 with transferring.

Interview with the DOC confirmed that the staff were expected to follow the direction for safe transferring when assisting residents with transfer using the specified lift and the description of the inspector observation indicated that resident #004 was not transferred using proper technique to transfer the resident. [s. 36.]

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 with ensuring that staff use safe transferring and positioning devices and techniques when assisting residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff only applied physical devices that had been ordered or approved by a physician or registered nurse in the extended class.

During stage two of the RQI, resident #011 was triggered for potential side rail restraint from observation during stage one. Observation by the inspector, during resident's care revealed that staff used specified bed rails, a specified trunk restraint and type of wheelchair for resident #011.

Interview with PSW #110 indicated that resident had restraints in place, using an identified type of wheelchair and specified trunk restraint when up in their wheelchair. Resident #011 additionally had two specified type bed rails for safety as the resident had involuntary movements and was at risk for falls.

Review of resident #011's health records revealed that the attending physician had ordered the specified trunk restraint for use when the resident was up in their wheelchair. The review failed to reveal an order or approval for the staff to use bed rails or the specified function of their wheelchair as a restraint.

Interview with RN #124 confirmed that the resident did not have an order or approval for staff to use a bed rails or the specified function of the wheelchair for resident #011.

Interview with the DOC confirmed that staff were expected to follow the process of applying a restraint device to the resident and one of the processes was to ensure doctors order or approval was obtained. [s. 110. (2) 1.]

2. The licensee has failed to ensure that staff applied the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

This inspection protocol was inspector initiated inspection for resident #004 regarding minimizing of restraint due to identified concerns during the inspection of a complaint and CIR .

Review of resident #004's MDS assessment revealed the resident had a trunk restraint applied during the observation period.

Review of the resident #004's written plan of care revealed that the resident exhibited specified responsive behaviours and was at risk for falls. Resident #004 had a specified trunk restraint put in to place on the recommendation following a consultation with a specialized resource on an identified date. Review of physician orders revealed that the specified trunk restraint was to be applied when the resident was up in the wheelchair for

safety, to be released, reposition the resident and reapply the restraint every one hour (q1h).

Review of the written plan of care indicated the specified trunk restraint to be released, reposition the resident and reapply q2h.

Review of the PSW daily documentation record failed to reveal if the trunk restraint was applied and released, if the resident was repositioned and if the restraint was reapplied every two hours as specified in the physician order.

Interview with PSW #120 revealed that they checked and repositioned the resident every two hours. Observation on two instances of how they repositioned the resident indicated the PSW did not release the specified restraint. When asked about releasing of the restraint, the PSW confirmed they did not always release the restraint as it is not included in the POC tasks.

Interview with DOC confirmed that the staff is expected to follow the physician instruction as specified in the order. The DOC also confirmed that the staff did not apply the physical device in accordance with instructions specified by the physician. [s. 110. (2) 2.]

3. The licensee has failed to ensure that the documentation of every use of a physical device to restrain a resident under section 31 of the Act included all assessments, reassessments and monitoring, including the resident's response.

During stage two of the RQI, resident #011 was triggered for potential side rail restraint from observation during stage one. Observation conducted on an identified, during resident's care revealed that staff used specified type bed rails, potential trunk restraint and specified wheelchair function for resident #011.

Review of resident #011's restraint/ PASD assessment record indicated the resident was assessed for using the specified wheelchair function only. The review failed to reveal an assessment for using the specified trunk restraint or bed rails. Further review of the resident's health record failed to reveal documentation indicating that the resident was reassessed, monitored or the resident's responses to the restraints.

Interview with PSW #110 revealed they documented when they checked on the device, but they did not monitor for resident's response to the device or document on the response.

Interview with RN #124 revealed that they were not aware of the content of the resident's plan of care regarding restraint/ PASD. The RN was not able to locate the resident's assessments or reassessment and monitoring, including the resident's response within the health record.

Interview with RAI Coordinator confirmed that the staff did not reassess resident #011, and did not evaluate the effect of the devices including the resident's response to the device. Interview with DOC confirmed that the staff had not documented reassessment and monitoring of the resident or their response as the home is transitioning to another system of documentation. [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 with ensuring that the following requirements are met when residents are restrained by a physical device under section 31 of the Act:
- that staff only apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class,
- that staff apply physical devices in accordance with any instructions specified by the physician or registered nurse in the extended class, and
- ensuring that every use of a physical device to restrain a resident under section 31 of the Act is documented including all assessments, reassessments, monitoring and resident response, to be implemented voluntarily.

WN #10: 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 an interdisciplinary medication management system was developed that provided safe medication management.

a. Observation of medication administration to resident #046 by RPN #112 was conducted by the inspector. RPN #112 was observed administering medication to resident #046 pouring the medications from their medication strip pack.

A review of resident #046's current Electronic Medication Administration Record (EMAR) identified an order for 500 mg of a specified medication.

A review of resident #046's medication strip pack labeled with an identified date and time identified 1250mg of the specified medication.

In an interview, RPN #146 verified resident #046's medication strip pack indicated 1250mg of the specified medication and that the resident's EMAR indicated 500mg of the specified medication. The RPN acknowledged that there was a discrepancy between the medication strip pack and the EMAR. The RPN indicated that the dosage the resident should have been administered was 500mg.

In an interview, Pharmacist #156 verified resident #046's medication strip pack indicated 1250mg of the specified medication and that the resident's EMAR indicated 500mg of the specified medication. The Pharmacist indicated that the medication was a combination of 500mg of the elemental form the specified medication and 750mg of carbonate totaling 1250mg which was identified on the resident's medication strip pack. The Pharmacist indicated that the actual dose of the specified medication the resident had received was 500mg. Pharmacist #156 acknowledged that resident #046's medication strip pack and the resident's EMAR should match.

In an interview, the DOC verified that resident #046's medication strip pack indicated 1250mg of the specified medication and that the resident's EMAR indicated 500mg of the medication. The DOC acknowledged that there should be consistency with the medication strip pack and the EMAR and the order for the specified medication should be the same on both strip pack and EMAR.

b. Observation of medication administration for resident #026 was conducted by the inspector with RPN #127. During the medication observation the inspector had observed

the RPN take the residents medication pouches out for the identified administration time. A review of the medication pouches indicated 1250mg of a specified medication, the physician order indicated 500mg of the specified medication, and the EMAR displayed 500mg of the specified medication.

An interview conducted with RPN #127 stated the physician's medication order, EMAR order, and the medication pouch are to match the resident's medication profile. The RPN reviewed the physician order, EMAR display, and the medication pouch for resident #026 and confirmed the medication pouch did not indicate 500mg of the identified medication, instead stating 1250mg of the identified medication. The RPN was unable to explain why the pouch indicated 1250mg of the specified medication. The RPN stated when they have questions related to medication they contact the pharmacy provider.

An interview conducted with Pharmacist #156 indicated the pharmacy provides the home with pharmacy services and can be contacted at any time for any medication related questions. The Pharmacist was informed of the physician order for 500mg of the specified medication, EMAR order displayed 500mg of the specified medication, and the medication pouch showed 1250mg of the specified medication. The inspector asked as to why the physician's order, EMAR display, and the medication pouch information was the same. The Pharmacist acknowledged not all three showed the same dosage and stated the specified medication is a mixture of two medications thus the medication breakdown consisted of 500mg of the specified medication and 750mg of carbonate which equaled 1250mg. The Pharmacist indicated they understood the discrepancy and confusion which could occur as all three medication doses did not match. [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 with developing an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was secure and locked.

Observations by the inspector revealed two containers of topical creams prescribed for resident #008 on metal shelf in the resident's washroom. One container contained an identified topical medication with approximately 10 percent of the medicated cream remaining. Another container contained an identified topical medication with approximately 90 percent of the medicated cream remaining.

In an interview, RPN #112 verified that there were two containers of topical creams prescribed for resident #008 left in their washroom. The RPN indicated that the topical creams should be stored in the treatment cart and removed them from the washroom.

Observations by the inspector revealed a container containing topical cream prescribed for resident #045 on a metal ledge in the resident's washroom. The container contained an identified topical medication with approximately 10 percent of the medication remaining.

In an interview, RN #112 verified the container of topical cream prescribed for resident #045 left in their washroom and indicated that it should not be there. The RN indicated that the topical creams should be stored in the treatment cart in the medication room. RN removed the topical cream from the resident washroom.

In an interview, the DOC indicated that they had been informed of topical creams being left in resident's rooms and that this should not have occurred. The DOC indicated that topical creams are to be stored in the treatment cart and locked in medication room [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 with ensuring that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #12: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review,
(b) any changes and improvements identified in the review were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

In an interview, the DOC indicated that the home's medication incidents are reviewed at the quarterly Professional Advisory Committee (PAC) meetings where they are reviewed by the medical director. The DOC stated that the medication incidents are reviewed and analyzed in order to identify any trends and indicated the last PAC meeting was held in two quarters prior and the most recent quarter's meeting was canceled at the last minute. The DOC later informed the inspector they were unable to show evidence of the PAC meeting minutes related to the review an analysis of the medication incidents from the meeting held two quarters prior.

Interim Administrative Assistant (IAA) #153, provided the inspector with the PAC meeting minutes from the last held meeting, upon review of the minutes there was no evidence indicating medication incident where reviewed and analyzed.

Further interview with the DOC indicated they recalled that at the core physician meetings the home did review and analyze the medication incidents but indicated they were unable to show evidence of the review. The DOC acknowledged that there has not been a quarterly review of the medication incidents for the two past quarters, and was unable to produce documentation of the quarterly review of medication incidents and adverse drug reactions. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with:
- ensuring that a quarterly review is undertaken of all medication incidents and adverse drug reactions that occur in the home,
- ensuring that any changes and improvements identified in the review are implemented, and
- ensuring a written record is kept of the quarterly reviews and any changes and improvements implemented, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that all plumbing fixtures were maintained and kept free of corrosion.

During the resident observation in stage one, the inspector observed resident #008's washroom sink plumbing fixture and the toilet plumbing fixture to be corroded. The inspector additionally observed resident #010's washroom sink faucet to be corroded and scaled.

On a subsequent observation, the inspector observed resident #008's washroom sink plumbing fixture to be corroded and had a buildup of a greenish and light brown substance that came away from the fixture when touched. The area underneath had been damp to the touch. The toilet plumbing fixture had areas of rust and the cap had separated from the wall. The inspector observed a filmy build-up on both of resident #010's washroom sink faucets and water spout. The left faucet's edges were corroded and scaled. The sink's plumbing fixtures were rusted, corroded and had a buildup of a greenish substance. The sink's plumbing fixture also had an area with hard brownish buildup.

During an interview with the Environmental Services Supervisor (ESS), they verified the lime buildup on resident #010's washroom sink faucets and water spout. The ESS indicated that housekeeping staff have chemicals they should have been using on the fixtures and would review the process with the housekeeping staff. The ESS additionally verified the lime buildup and dirt on the resident's #008 washroom sink's plumbing fixture, the rust to the toilet fixture and that the cap had separated from the wall. The ESS indicated that housekeeping staff should have used their product for lime build-up. The ESS stated the expectation of the home was to have the issues with these plumbing fixture submitted in the electronic maintenance tracking system so further action could be implemented. [s. 90. (2) (d)]

Issued on this 16th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), GORDANA KRSTEVSKA (600), NATASHA MILLETTE (686), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2018_420643_0001
Log No. / No de registre :	011028-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2018
Licensee / Titulaire de permis :	North York General Hospital 4001 Leslie Street, NORTH YORK, ON, M2K-1E1
LTC Home / Foyer de SLD :	Seniors' Health Centre 2 Buchan Court, NORTH YORK, ON, M2J-5A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Bock

To North York General Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The Licensee must be compliant with LTCHA 2007, c. 8, s. 6. (4).

Specifically, to ensure that the staff and others involved in the different aspects of care of residents #005, #009 and #014 and any other resident with weight variance, collaborate with each other in the assessment of the residents so that their assessments are integrated and consistent with, and complement each other.

Upon receipt of this compliance order the licensee shall prepare, submit and implement a plan to achieve compliance with LTCHA 2007, c. 8, s. 6. (4). The plan will include but not be limited to:
1. Development of a system to audit resident weights on a monthly basis to ensure residents with documented weight changes are re-weighed to verify the validity of the weight changes, and
2. Providing education to registered staff on the weight monitoring policy in the home to ensure that resident weight changes are monitored and evaluated from an interdisciplinary approach and that referrals to the Registered Dietitian are made when warranted.

Please submit the plan to adam.dickey@ontario.ca no later than February 27, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

a. During stage two of the resident quality inspection (RQI) nutrition and hydration was triggered for resident #005 related to staff interview during stage one.

Review of the home's policy titled Monitoring of Resident Weights, policy number VII-G-20.80, revised April 2016, revealed that the registered staff were to ensure that a resident be re-weighed if there was a difference in resident weight of two Kilograms (Kg) from the previous month. The registered staff were directed to investigate potential causes of weight variance including a review of eating patterns, hospitalizations, symptoms and observations including fluid retention. Registered staff were instructed to complete monthly weight variance reports and respond to weight variances in the electronic documentation and refer to the Registered Dietitian (RD if necessary. The RD was instructed to assess residents with identified weight variances, audit the monthly variance report, evaluate and update the electronic record

Review of resident #005's health records revealed they had been admitted to the home with identified medical diagnoses. Resident #005's plan of care indicated they were at moderate nutrition risk and required assistance from staff for feeding. Review of resident #005's weight history revealed significant weight losses in each month of an identified four month period.

In interviews, RN #129, RPN #112, RPN #113 and RPN #101 stated that it was the process in the home for residents to be weighed monthly by the PSW staff, input into the electronic record and in the case of a change in the resident recorded weight would be re-weighed to confirm the change in weight. RPN #113 stated that residents who have had a two kg change from the previous month weight to be re-weighed. RN #129, RPN #112, RPN #113 and RPN #101 stated that residents with significant weight changes should be referred to the Registered Dietitian (RD) for assessment. RN #129, RPN #112, RPN #113 and RPN #101 further stated that referrals to the RD are completed using the referral form under the assessment tab on PCC.

Review of the monthly weights form completed for November failed to reveal a re-weigh of resident #005's weight changes greater than 2Kg. Review of the assessment tab in PCC failed to reveal a referral for resident #005's significant weight changes. Review of resident #005's progress notes failed to reveal an assessment of the significant weight changes by the RD.

b. Due to identified noncompliance with O. Reg. 79/10, s. 69 related to resident #005, the sample of residents was expanded to include residents #009 and #014.

Review of resident #009's health records revealed they were admitted to the home with identified medical diagnoses. Resident #009's plan of care indicated they were at high nutrition risk due to poor intake, low body weight and required assistance from staff for feeding. Review of Resident #009's weight history revealed significant weight changes in each month over an identified three month period.

Review of the monthly weights form completed for the first identified month failed to reveal a re-weigh of resident #009's significant weight change greater than 2Kg. Review of resident #009's progress notes revealed a quarterly assessment was completed during the first identified month by RD #119 assessing Resident #009's significant weight change. There were no further progress notes documenting assessment of resident #009's subsequent weight loss in the second or third month of the above mentioned three month period. Review of assessment tab in PCC revealed no referrals were made to the RD regarding any of the above mentioned significant weight changes.

In an interview, RN #129 stated there had not been any referrals made to the RD regarding significant changes in resident #009's weight in the last five months. RN #129 further stated that resident #009 was having poor intakes and staff were discussing strategies frequently.

c. Review of resident #014's health records revealed they had been admitted to the home with identified medical diagnoses. Review of resident #014's care plan revealed they were at high nutrition risk and was fed via feeding tube. Resident #014 was found to have had a significant change in weight over an identified one month period.

Review of the monthly weights form completed for the above mentioned identified month failed to reveal a re-weigh of resident #014's weight change of greater than 2Kg. Review of assessments tab in PCC failed to reveal documented referral to the RD for resident #014's significant weight change over the identified one month period. Review of resident #014's progress notes failed to reveal an assessment of resident #104's identified significant weight change.

In an interview, RN #129 stated that no referrals were submitted to the RD regarding a significant weight change for resident #014. RN #129 further stated that a referral should have been communicated.

In an interview, RD #119 stated it was the process in the home for residents to be weighed each month and that it was the expectation that registered staff would complete a referral in PCC for residents with significant weight changes. RD #119 further stated that a weight variance report would be generated each month to further monitor resident weight changes. RD #119 acknowledged that no referrals were found nor assessment of significant weight changes of residents #005, #009 and #014 were completed.

In an interview, the DOC stated it was the expectation of the home for residents to be weighed at the beginning of each month and for any residents with a significant change to be re-weighed to confirm. Registered staff on the unit would then be required to assess if there was a reason for change in weight and refer to the RD for assessment. The DOC acknowledged that the staff and others involved in the different aspects of care of the residents failed to collaborate with each other in the assessment of the residents so that their assessments were integrated and were consistent with and complemented each other.

The severity of this issue was determined to be potential for actual harm to the residents. The scope of this issue was identified as widespread as it related to three out of three residents inspected. Review of the home's compliance history revealed they had ongoing noncompliance with a voluntary plan of correction (VPC) issued. Previous non-compliance with this section of the LTCHA included:
- Voluntary plan of correction (VPC) issued on January 24, 2017, under inspection report 2016_413500_0009. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s. 69. Specifically, for resident's #005, #009 and #014, and any resident with weight variances, the licensee shall ensure the following is in place for the home:
1. An auditing system to monitor that residents with weight changes outlined in the Regulation (O. Reg. 79/10, s. 69) are assessed using an interdisciplinary approach,
2. A process that ensures actions are taken and outcomes are evaluated in response to resident weight changes, and
3. Maintain documentation of the auditing system and process that ensures actions are taken to be made available upon inspector request.

Grounds / Motifs :

1. The licensee has 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:
- A change of 5 per cent of body weight, or more, over one month;
- A change of 7.5 per cent of body weight, or more, over three months; and
- A change of 10 per cent of body weight, or more, over 6 months.

a. During stage two of the RQI nutrition and hydration was triggered for resident

#005 related to staff interview during stage one.

Review of resident #005's health records revealed they had been admitted to the home with identified medical diagnoses. Resident #005's plan of care indicated they were at moderate nutrition risk and required assistance from staff for feeding. Review of resident #005's weight history revealed the following significant weight changes over an identified four month period:
- A change of five per cent of body weight or more over one month;
- A change of 7.5 per cent of body weight, or more, over two months;
- A change of 7.5 per cent of body weight, or more, over three months; and
- A change of 10 per cent of body weight, or more, over four months.

In interviews, RN #129, RPN #112, RPN #113 and RPN #101 stated that it was the process in the home for residents to be weighed monthly and for residents with significant weight changes to be referred to the RD for assessment. RN #129, RPN #112, RPN #113 and RPN #101 further stated that referrals to the RD are completed using the referral form under the assessment tab on the electronic record.

Review of the assessment tab in the electronic record failed to reveal a referral for resident #005's significant weight changes. Review of resident #005's progress notes failed to reveal an assessment of the significant weight changes by the RD.

In an interview, RD #119 stated it was the process in the home for residents to be weighed each month and that it was the expectation that registered staff would complete a referral for residents with significant weight changes. RD #119 further stated that a weight variance report would be generated each month to further monitor resident weight changes. RD #119 acknowledged that no assessment of resident #005's significant weight changes was completed.

b. Due to identified noncompliance with O. Reg. 79/10, s. 69 related to resident #005, the sample of residents was expanded to include resident #009.

Review of resident #009's health records revealed they were admitted to the home with identified medical diagnoses. Resident #009's plan of care indicated they were at high nutrition risk and required assistance from staff for feeding. Review of Resident #009's weight history revealed the following significant weight changes over an identified three month period:

- A change of five per cent of body weight or more over one month;
- A change of 7.5 per cent of body weight, or more, over two months; and
- A change of 7.5 per cent of body weight, or more, over three months.

Review of resident #009's progress notes revealed a quarterly assessment was completed by RD #119 on an identified date, which included an assessment of the resident's significant weight change over the first identified month. There were no further progress notes documenting assessment of resident #009's subsequent weight changes in following two months. Review of assessment tab in the electronic record revealed no referrals were made to the RD regarding any of the above mentioned significant weight changes.

In an interview, RN # 129 stated there had not been any referrals made to the RD regarding significant changes in resident #009's weight since August. RN #129 further stated that resident #009 was having poor intakes and staff were discussing strategies frequently.

In an interview, RD #119 stated that resident #009 was already receiving nutrition interventions and and had been assessed on the above mentioned identified date. RD #119 acknowledged that no assessments of significant weight changes over the next two months were completed and that no referral was received to assess these changes in weight.

c. Due to identified noncompliance with O. Reg. 79/10, s. 69 related to resident #005, the sample of residents was expanded to include resident #014.

Review of resident #014's health records revealed they had been admitted to the home with identified medical diagnoses. Review of resident #014's care plan revealed they were at high nutrition risk and were on an enteral feeding regimen. Resident #014 was found to have had a significant change in weight of five per cent of body weight or more over one identified month.

In an interview, RN #129 stated that no referrals had been submitted to the RD regarding a significant weight change for resident #014. RN #129 further stated that a referral should have been communicated.

Review of assessments tab in the electronic record failed to reveal a referral to the RD for resident #014's significant weight change over the identified one month period. Review of resident #014's progress notes failed to reveal an

assessment of resident #014's significant weight change.

In an interview, RD #119 acknowledged that resident #014's significant weight change was not assessed as he/she had not received a referral. RD #119 stated they were not aware of the documented change in weight that month and that it was probably a measurement error.

In an interview, the DOC stated it was the expectation of the home for residents to be weighed at the beginning of each month and for any residents with a significant change to be re-weighed to confirm. Registered staff on the unit would then be required to assess if there was a reason for change in weight and refer to the RD for assessment. The DOC acknowledged that residents #005, #009 and #014 who had documented significant weight changes were not assessed using an interdisciplinary approach.

The severity of this issue was determined to be potential for actual harm to the residents. The scope of this issue was identified as widespread as it related to three out of three residents inspected. A review of the home's compliance history revealed that they had one or more unrelated noncompliance issued in the last three years. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s. 74 (2). Specifically, the Licensee shall ensure the following is in place for the home:
1. An auditing system to ensure Registered Dietitian on-site attendance is documented and tabulated to ensure the clinical and nutrition care duties are carried out for a minimum of 30 minutes per resident per month,
2. A Registered Dietitian(s) who is/are a member of the staff of the home that is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, and
3. Maintain a record of Registered Dietitian clinical and nutrition care hours to demonstrate the home is meeting the requirements as outlined in O. Reg. 79/10, s. 74 (2).

Grounds / Motifs :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

Review of the home's License information indicated there were 192 licensed long-term care beds in the home. Based on 192 beds, the licensee is required to ensure that an RD is on site at the home for 96 hours per month, to carry out clinical and nutrition care duties. Review of hours logged by RD #119 and RD #152 revealed the following monthly hours:
- December 2017, RD #119 was on site for 76.5 hours, RD #152 was on site 6.5 hours for a total of 83 hours;
- November 2017, RD #119 was on site for 95 hours;
- October 2017, RD #119 was on site for 90.5 hours; and

- September 2017, RD #119 was on site for 80.5 hours, RD #152 was on site for 12.5 hours for a total of 93 hours.

In an interview, RD #119 stated that they were one of two RDs who has been working in the home over the past year. RD #119 stated that they had been working Mondays and Thursdays each week and covering all clinical and nutrition care duties for all residents in the home. RD #119 stated that RD #152 was working on a casual basis and had covered some hours in December while RD #119 was away. RD #119 stated that they had been working longer days of 10 to 11 hours in order to cover all the clinical and nutrition care duties and has been working approximately 40 hours bi-weekly. RD #119 was aware that the required hours for a RD on site at the home was 96 hours per month.

In an interview, Food Services Supervisor (FSS) #103 stated that it was the expectation of the home that based on 192 beds a RD should be on site to carry out clinical and nutrition care duties for 96 hours based on 30 minutes per resident per month. FSS #103 further stated that RD #119 was on site two days per week and was working longer hours of 10 to 11 hours each day on site. FSS #103 stated that RD #119 was working between 88 and 94 hours per month. FSS #103 further stated that RD #152 was filling in for some hours on a casual basis and a position was currently posted for a casual part time RD which had not been filled.

In an interview, the administrator stated that it was the expectation of the home for a RD to be on site for 30 minutes per resident per month. The administrator acknowledged that the licensee had failed to ensure that a registered dietitian who was a member of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The severity of this issue was determined to be potential for actual harm to the residents. The scope of this issue was identified as widespread, as it had the potential to affect all residents in the home. The home had a level two compliance history as they had one or more unrelated noncompliance issues in the last three years. (643)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 21, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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