Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 27, 2018	2018_525596_0001	000673-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

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

THERESA BERDOE-YOUNG (596), JOY IERACI (665)

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 10, 11, 12, 15, 16, 17, 18, 19, 22 and 23, 2018.

Follow up log #011214-17 related to abuse and neglect was inspected concurrently with this Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Registered Dietitian (RD), Manager of Resident Services (MRS), Acting Nurse Managers (ANM), Nurse Managers (NM), registered nurses (RN), registered practical nurses (RPN), support service workers (SSW), personal care aides (PCA), Family Council president, Residents' Council president, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care and staff to resident interaction, observed medication administration, provision of care, reviewed resident health records, meeting minutes, training record, schedules, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

10 WN(s)
3 VPC(s)
0 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. 23. (1)	CO #001	2017_414110_0005	596

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

The continence care and bowel management inspection protocol (IP) triggered from stage one of the resident quality inspection (RQI) related to a change in continence status for resident #004.

Review of resident #004’s current written plan of care dated October 29, 2017, revealed the resident was incontinent of both bowel and bladder and used a particular size brief for incontinence.

Interviews with registered practical nurses (RPNs) #111 and #115 indicated residents should be assessed to determine the appropriate incontinent product to be used. Interviews with RPNs #111 and #112 and personal care aides (PCA) #110 and #113 indicated the resident home area (RHA) has a resident profile worksheet which identifies the assessed incontinent product for each resident. Review of the resident profile worksheet dated January 15, 2018, with RPNs #111, #112 and PCA #110 revealed the resident was assessed to use the same particular size brief as indicated in the resident's plan of care mentioned above.

Observations conducted on a specified date in January 2018, with RPNs #109, #112 and PSW #110, revealed the resident was wearing a different brief instead of the one indicated on the resident profile worksheet. PSW #110 indicated the brief the resident was wearing was more absorbant than the brief the resident was assessed for. The staff indicated it was the home’s expectation for the resident's plan of care to be followed. They acknowledged the plan of care was not followed for resident #004 as the incorrect incontinent product was used.

Interview with Acting Nurse Manager (ANM) #130, who was also the home's Continence Lead indicated it was the home’s expectation for the resident's plan of care to be followed by all staff. The ANM acknowledged that the care set out in the plan of care was not provided to resident #004 as specified in the plan, as the incorrect incontinent product was used. [s. 6. (7)]

2. The continence care and bowel management IP triggered from stage one of the RQI related to a change in continence status for resident #002.

Review of resident #002's current written plan of care dated October 31, 2017, under the continence care focus revealed the resident was usually continent of bowel and on a scheduled toileting plan. The toileting plan indicated that the resident was to be toileted before meals, at bedtime and as required.

Observation conducted on a specified date in January 2018, from 1100 hours (hrs) to 1200 hrs found the resident sitting in the TV lounge in their wheelchair and did not observe the PCA staff toilet the resident before the lunch meal service.

Interview with PCA #114 indicated it is the home's expectation for the plan of care to be followed by all staff. The PCA stated the resident was not toileted before lunch as specified in the plan of care.

Interview with ANM #130/continence lead indicated it is the home's expectation for residents' plan of care to be followed by all staff. The ANM acknowledged that the care set out in the plan of care was not provided to resident #002 as specified in the plan related to the resident's scheduled toileting plan. [s. 6. (7)]

3. The minimizing of restraining IP triggered from stage one of the RQI related to potential restraint device for resident #002.

Review of resident #002's plan of care revealed the use of a particular assistive device when the resident was sitting in the wheelchair.

Observations conducted on a specified date in January 2018, at 1445 and 1650 hrs, found the resident sitting in their wheelchair with a particular restraining device applied.

Interviews with PCAs #114 and #116 confirmed they had applied the restraining device to resident #002. PCA #114 stated they applied the restraining device accidentally and PCA #116 stated it was applied as the resident pushes the assistive device to the side. Both PCAs considered the particular restraining device to be a physical restraint and was not part of the plan of care for the resident. The PCAs acknowledged they did not follow the plan of care for resident #002.

Interview with ANM #124 indicated it is the home's expectation for staff to follow residents' plan of care. The ANM stated the plan of care for resident #002 included the use of a particular restraining device as a physical restraint, which was different from the

type of restraining device that the inspector observed the staff using on the resident, as mentioned above. They acknowledged the care set out in the plan of care was not provided by PCAs #114 and #116 for resident #002. [s. 6. (7)]

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

Review of the home’s medication incidents for a three month period revealed one medication incident report involving resident #025 on two specified dates in July 2017.

Review of resident #025’s medication administration record (MAR) for a one month period revealed missing signatures on a specified date in July 2017, for the resident’s 1200 hrs dosage of a particular medication, as well as glucometer checks twice daily on two specified dates in July 2017.

Interview with RPN #141 indicated it is the home’s policy for nurses to document on the MARs when medication and glucometer checks are given and completed. The RPN stated the above mentioned particular medication was administered to the resident and the glucometer check were completed, but they forgot to document on the MARs.

Interview with the Director of Nursing (DON) indicated it is the home’s expectation for registered staff to document on the MARs when medication or treatment is administered. The DON acknowledged RPN #141 did not follow the home’s expectation as the provision of care in the plan of care was not documented. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Nutrition and Hydration IP triggered from stage one of the RQI for resident #007 related to no plan, low body mass index (BMI).

Record review of resident #007's plan of care indicated a goal that they will maintain or gradually increase current weight to a specified weight goal range. Interventions included: monitor weight monthly, and food and fluid intake. Report to registered staff if the resident leaves 25% of food and fluids at most meals (at least two out of three meals/day).

Record review of the resident's most recent nutrition assessment indicated that the resident had a moderate nutrition risk status.
Record review of the resident's nursing and personal care record (NPCR) for food and fluid intake for January 2018, revealed no documentation for the amount of food and fluids consumed at breakfast and lunch on three specified dates in January 2018.

Interview with RN #107 revealed they worked on the above mentioned dates and should have documented the resident's intake for breakfast and lunch, but thought that the PCA did it.

Interview with the DON acknowledged that the home's expectation is that the registered staff document residents' meal consumption on the NPCR for food and fluid intake. [s. 30. (2)]

2. The Nutrition and Hydration IP triggered from stage one of the RQI for resident #005 related to no plan, low BMI.

Record review of resident #005's plan of care indicated a goal that they will increase current weight to a specified weight goal range. Interventions included: monitor weight monthly, and food and fluid intake. Report to registered staff if the resident leaves 25% of food and fluids at most meals (at least two out of three meals/day).

Record review of the resident's nutrition assessment indicated that the resident had a moderate nutrition risk status.
Record review of the resident's NPCR for food and fluid intake for January 2018, revealed no documentation for the amount of food and fluids consumed at dinner on four specified dates in January 2018.

Interviews with RN #122 and RPN #121 revealed the resident's meal consumption was not reflected on the NPCR for food and fluid intake on the above mentioned dates. RN #122 stated that they worked evenings on three specified dates in January 2018, but was not aware that they were supposed to complete the above mentioned documentation for resident #005. RPN #121 confirmed that they worked on one specified date in January 2018, and the resident's husband fed him/her dinner. RPN #121 stated they were not aware that they should have documented the resident's meal consumption. The above mentioned RPN and RN stated that they thought the PCA staff were responsible for documenting residents' meal consumption.

Interview with the DON indicated the home's expectation is that the registered staff document residents' meal consumption on the NPCR for food and fluid intake. [s. 30. (2)]

3. The nutrition and hydration IP triggered from stage one of the RQI related to no plan, low BMI for resident #002.

Review of resident #002’s progress notes by the RD dated August 23, 2017, revealed a low BMI. The quarterly nutrition review progress note of a specified date in October 2017, revealed the resident’s BMI decreased, weight declined and the resident was at a high nutritional risk.

Interviews with PCAs #114, #116 and #127, RPN #126 and RN #128 indicated it is the home’s policy for food and fluid intake to be documented for each resident on the NPCR for food and fluid intake. The staff indicated that registered staff are to document food and fluids consumed during meals and the PCAs are to document snacks and fluids at snack time on the NPCR for food and fluid intake.

Review of the resident’s NCPR for food and fluid intake for the period of sixteen days in January 2018 revealed missing documentation for meals and fluid intake for nine specified dates in January 2018, by both registered staff and PCAs.

Interviews with RPN #126 who worked on two specified dates in January 2018, and RN #128 who worked on one of the specified dates in January 2018, confirmed they did not document the amount of food and fluids consumed by the resident. Interviews with PCAs #114 and #116 who worked on the second specified date in January 2018, confirmed they did not document food and fluid intake of the resident at snack time. The staff indicated the resident was at a high nutritional risk and they did not follow the home’s food and fluid intake policy on documentation.

Interview with RD #103 indicated the NPCR for food and fluid intake is reviewed to assess the nutrition and hydration needs of resident #002. The RD indicated when the food and fluid intake is not documented, it is more of a challenge to assess the nutrition and hydration needs of residents. The RD stated resident #002 was at a high nutritional risk and continues to have a low BMI.

Interview with the ANM #124 indicated it is the home’s expectation for resident's food and fluid intake to be documented by staff on the NPCR for food and fluid intake. The ANM stated the registered staff document the food and fluids consumed by residents at meals and the PCAs document residents' food and fluid intake at snack time. The ANM reviewed resident #002’s NPCR for food and fluid intake for the month of January 2018, and acknowledged staff did not follow the home’s policy on documenting food and fluid intake for resident #002. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The skin and wound care IP was triggered from stage one of the RQI related to altered skin integrity for resident #011.

Review of the resident's MDS assessments dated on a specified date in August and one in November 2017, revealed resident #011 had a new area of altered skin integrity in the November assessment.

Review of resident #011's progress notes for a specified date in January 2018, by the nurse practitioner (NP) revealed that the resident had an area of altered skin integrity and another medical condition to a specified body part. A progress note for a specified date in November 2017, revealed the discovery of an area of altered skin integrity. Another progress note by the physician dated September 19, 2017, revealed the resident had another area of altered skin integrity to a body part.

Interviews with RPNs #145, #118 and #139 stated it is the home’s expectation for a weekly skin assessment to be completed for the resident on the weekly ulcer/wound assessment record until the wound has healed.

Review of the weekly ulcer/wound assessment records with RPN #118 revealed weekly assessments were completed for the first area of altered skin integrity on one specified date in November, two specified dates in December 2017, and two specified dates in January 2018. Weekly ulcer/wound assessment for the resident’s second area of altered skin integrity was not located except for on a specified date in October 2017. The RPN reported the resident continued to have altered skin integrity to two body parts. After reviewing the weekly ulcer/wound assessment records the RPN indicated weekly assessments were not completed as per expectation; two assessments were not completed in December 2017 and no assessments were completed for an area of altered skin integrity, since early October 2017.

Review of the resident's MARs for the period of one month from December 2017, to January 2018, revealed weekly wound assessments were scheduled during the evening shift on three consecutive weeks in December 2017, and one in January 2018, but did not have nursing signatures on the specified dates.

Interview with RPN #145 confirmed they worked on one of the specified dates in December 2017, and did not complete the weekly skin assessment as wound care was completed by the night nurse. The RPN reviewed the weekly ulcer/wound assessment records and acknowledged two weekly assessments were not completed in December 2017 for one area of altered skin integrity, and the weekly assessments were not completed since early October 2017 for another area of altered skin integrity.

Interview with the DON revealed it is the home’s expectation for weekly skin assessments to be completed on the weekly ulcer/wound assessment record for all wounds until healed. The DON reviewed the weekly ulcer/wound assessment record for resident #011’s two areas of altered skin integrity and stated weekly ulcer/wound assessments were not consistently done by the registered staff. The DON acknowledged staff did not follow the home’s expectation to complete weekly reassessment of resident #011’s wounds. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any system instituted or otherwise put in place was complied with.

The Nutrition and Hydration IP triggered from stage one of the RQI for resident #007 related to no plan, low body mass index (BMI).

According to O. Reg. 79/10, s 68. (1) (e) every licensee of a long term care home shall ensure that they have a weight monitoring
system to measure and record weight on admission and monthly thereafter, with respect to each resident.

The home's policy titled unplanned weight changes, #RC-0523-13, published January 8, 2015, indicates that staff should take and record resident's weight on a monthly basis before the tenth day of the month.

Record review of resident #007's plan of care indicated a goal that they will maintain or gradually increase current weight to a specified weight goal range. Interventions included: monitor weight monthly, and food and fluid intake. Report to registered staff if the resident leaves 25% of food and fluids at most meals (at least two out of three meals/day).

Record review of the resident's most recent nutrition assessment indicated that the resident had a moderate nutrition risk status.

Record review of resident #007's weight and height monitoring record revealed documentation of the resident's monthly weights for December 2017 and January 2018. There were no monthly weights documented for August and October 2017.

Interview with the registered dietitian (RD) revealed that the resident's monthly weights should be documented and they were missed in August and October 2017. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident’s plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device was included in the plan of care.

The minimizing of restraining IP triggered from stage one of the RQI related to potential restraint device for resident #005.

The inspector observed resident #005 on a specified date in January 2018, from 1245 to 1410 hrs sitting reclined in a wheelchair in a lounge area with three other residents. The inspector later observed the resident again at 1635 hrs sitting in the same area reclined in the wheelchair, with a registered staff and PCA nearby.

Record review of resident #005's plan of care did not include use of the wheelchair in a reclined position.

According to PCA #105, #101, RNs #122 and #102, reclining resident #005's wheelchair was preventing the resident from getting up and not included in the plan of care. All staff stated the resident would try to get up or slide out of the wheelchair if it wasn't reclined and it should be included in the plan of care. They reported that the wheelchair in a reclined position was a restraint for resident #005. [s. 31. (1)]

2. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

The minimizing of restraining IP triggered from stage one of the RQI related to potential restraint device for resident #005.

The inspector observed resident #005 on a specified date in January 2018, from 1245 to 1410 hours sitting reclined in a wheelchair in a lounge area with three other residents. The inspector later observed the resident again at 1635 hours sitting in the same area reclined in the wheelchair, with a registered staff and PCA nearby.

Record review of resident #005's clinical record did not include an order by the physician or registered nurse in the extended class for use of the wheelchair in a reclined position.

According to PCA #105, #101, RN #122, RN #102, if the wheelchair was not reclined the resident would try to get up or slide out of the wheelchair. Reclining resident #005's wheelchair prevented him/her from getting up and was considered a restraint.
RNs #122 and #102 stated that there was no physician's order for use of the wheelchair in a reclined position, and there should be. [s. 31. (2) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The continence care and bowel management IP triggered from stage one of the RQI related to a change in continence status for resident #004.

Record review of resident #004's MDS assessment revealed there was a change in the resident's bladder and bowel status. The MDS assessment of a specified date in December 2017, revealed the resident was frequently incontinent of both bladder and bowel, and the MDS assessment of a specified date in September 2017, revealed resident was incontinent of bladder and bowel.

Interviews with PSWs #108 and #113 indicated the resident used to be totally incontinent a few months ago and confirmed that the resident was not as incontinent as before.

Interviews with RPNs #109 and #111 indicated it is the home's expectation that a continence assessment should be completed when there is a change in continence status. The RPNs reviewed the resident's clinical records and indicated a continence assessment was not completed in December 2017, when there was a change in status. Both registered staff acknowledged the home did not follow the home's expectation in the completion of a continence assessment for resident #004, when there was a change in continence status.

Interview with ANM #130/continence lead indicated it is the home's process for a continence assessment be completed when there is a change in residents' continence status. The ANM reviewed resident #004's clinical records and did not locate a continence assessment for December 2017. The ANM acknowledged resident #004 did not receive a continence assessment when there was a change in bladder and bowel continence as per the home's expectation. [s. 51. (2) (a)]

2. The continence care and bowel management IP triggered from stage one of the RQI related to a change in continence status for resident #002.

Record review of resident #002's MDS assessments revealed there was a change in the resident's continence status for bowel. The MDS assessment of a specified date in October 2017, revealed the resident was usually continent of bowel and the MDS assessment of a specified date in August 2017, revealed the resident was frequently incontinent of bowel.

Interviews with PSW #116 and #125 indicated the resident was usually continent of bowel when toileted.

Interviews with RPN #115 and RN #117 indicated it is the home's expectation for a continence assessment to be completed when there is a change in continence status. The registered staff reviewed the resident's clinical record and indicated a continence assessment was not completed in October 2017, when there was a change in resident's bowel continence as per the October 2017 MDS assessment. They stated that a continence assessment should have been completed for resident #002 when there was a change in continence status.

Interview with ANM #130/continence lead indicated it is the home's expectation that a continence assessment should be completed when there is a change in residents' continence status. The ANM reviewed resident #002's clinical records and did not locate a continence assessment for October 2017. The ANM acknowledged resident #002 did not receive a continence assessment when there was a change in bowel continence as per the home's expectation. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents’ Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home’s mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home’s procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home’s policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents’ Council meetings, with the consent of the Residents’ Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information of copies of the inspection reports from the past two years for the long-term care home was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the initial tour of the home on January 10, 2018, inspection reports #2017_524662_0002 and #2016_288549_0012 were not posted in the home. The Administrator reviewed the inspection reports and confirmed the above mentioned reports were not posted. [s. 79. (3) (k)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that what alternatives were considered and why those alternatives were inappropriate was documented.

The minimizing of restraining IP triggered from stage one of the RQI related to potential restraint device for resident #005.

The inspector observed resident #005 on a specified date in January 2018, from 1245 to 1410 hrs sitting reclined in a wheelchair in a lounge area with three other residents. The inspector later observed the resident again at 1635 hours sitting in the same area reclined in the wheelchair, with a registered staff and PSW nearby.

Record review of resident #005's plan of care included the home's completed initiation of physical restraint form and a physician's order for the particular restraining device signed and dated on two specified dates in January 2018.
Review of the resident's clinical records did not include documentation regarding alternatives considered before initiating the above mentioned restraining device.

Interview with RN #102 stated that the resident's plan of care did not include documentation regarding alternatives considered before initiating use of the particular restraining device for resident #005, and it was missed.

Interview with NM #138 revealed that upon commencing use of restraints for any resident documentation should be completed in the progress notes regarding reason for restraint and alternatives considered, and it was not done for resident #005.

Interviews with PCAs #105, #101, RNs #122 and #102 confirmed that resident #005 was using a restraining device. [s. 110. (7) 2.]

2. The licensee failed to ensure that every use of a physical device to retrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessment, reassessment and monitoring, including the resident's response are documented.

The minimizing of restraining IP was triggered from stage one of the RQI related to potential restraint device for resident #002.

Review of resident #002's clinical records revealed a physician's order on a specified date in September 2017, for the use of a particular restraining device when the resident was seated in the wheelchair.

Interviews with RPN #115 and RN #117 revealed the assessment of a physical device to restrain a resident is documented on the initiation of physical restraint assessment form. RN #117 reviewed the resident's clinical records and did not locate the assessment form.

Review of the resident's clinical records did not locate the assessment form, when the resident's restraining device was initiated on a specified date in September 2017. Interviews with ANMs #124 and #130 indicated it is the home's expectation for an assessment to be completed and documented on the initiation of physical restraint form when initiating a physical restraint. Both ANMs reviewed the resident's clinical records and did not locate the assessment form. ANM #130 acknowledged the home did not follow expectation in documenting the assessment of resident #002's restraining device. [s. 110. (7) 6.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessment, reassessment and monitoring, including the resident's response was documented.

The minimizing of restraining IP triggered from stage one of the RQI related to potential restraint device for resident #002.

Review of resident #002's clinical records revealed a physician's order on a specified date in September 2017, for the use of a particular restraining device when the resident was seated in a wheelchair.

Interviews with RNs #128 and #117 and PCAs #114 and #116 revealed when a resident used a restraint, the restraint was released and the resident repositioned every hour; it should be documented on the restraining device monitoring record. The staff indicated both registered staff and PCAs are to document on the restraining device monitoring record every hour.

Review of the restraining device monitoring record for the period of November 1, 2017, to January 16, 2018, revealed missing documentation by the registered staff on 56

identified days and missing documentation by the PCA staff on 17 identified days.

Interviews with RN #128 who worked on a specified date in January 2018, and PCA #114 who worked on another specified date in January 2018, confirmed they did not document on the restraining device monitoring record for resident #002 as per home's expectation. Both staff indicated it is important that documentation is completed on the monitoring record to ensure the safety of the resident.

Interview with ANM #124 indicated that it is the home's expectation for registered staff and PCAs to document every hour on the restraining device monitoring record when a physical restraint is in use. The ANM reviewed the restraining device monitoring records for the resident and acknowledged the staff did not ensure that every release of the device and all repositioning were documented. [s. 110. (7) 7.]

WN #9: 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 failed to ensure that a written record was kept of everything when a quarterly review was undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents; and any changes and improvements identified in the review are implemented.

Interview with the DON indicated the last review of all medication incidents was for the period of July to September 2017. Review of the medication incidents for the quarter revealed one medication incident. The DON stated medication incidents were reviewed and analyzed during the quarterly Health Advisory Committee (HAC) meetings but the results of the quarterly review were not documented. [s. 135. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that continence care and bowel management training was provided to all staff who provide direct care to residents.

Review of the home's staff training records for 2017, revealed 30% of staff who provided direct care to residents did not receive training on the home's continence care and bowel management program.

Interview with the DON indicated it was the home's expectation for 100% of staff who provide direct care to residents receive training on continence care and bowel management. The DON acknowledged all direct care staff did not receive training as per expectation. [s. 221. (1) 3.]

2. The licensee has failed to ensure that training was provided to all staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

Review of the home's staff training records for 2017, revealed 30% of staff who apply physical devices or monitor residents restrained by physical devices did not receive training.

Interview with the DON indicated it was the home's expectation for 100% of staff to receive training on physical devices. The DON acknowledged all direct care staff did not receive training as per expectation. [s. 221. (1) 5.]

Issued on this 27th day of February, 2018

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

Original report signed by the inspector.