Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 30, 2017	2017_615638_0007	032464-16, 035281-16, 000732-17, 001017-17, 002103-17, 002860-17, 002861-17, 003060-17, 004960-17	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 2, 6-10 and 13-17, 2017.

The following intakes were completed in this Complaint inspection;
-One log was related to continence care as well as skin and wound care;
-One log was related to resident's responsive behaviours;
-Three logs were related to incidents of resident to resident abuse;
-Three logs were related to improper care; and
-One log was related to the home's complaint process.

A Critical Incident System (CIS) inspection #2017_615638_0008, was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, acting Director of Care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Registered Dietician (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs, relevant training and health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be properly cared for in a manner consistent with their needs.

A complaint was submitted to the Director related to resident care needs not being met in a timely manner. The complaint indicated that residents frequently had to wait long periods of time for their care needs to be met after notifying staff they require assistance via the call bell communication system.

Inspector #638 reviewed resident #002's progress notes, which indicated that in October 2016, resident #002 was found in their bathroom "screaming for help". The notes indicated that the resident was very upset and informed RPN #112 that PSW #113 had cancelled their call bell and never returned to assist them. The resident stated that they attempted to complete their own care. The progress notes further identified on the next day, that resident #002 had refused to settle into bed because they felt as though staff did not respond to their needs in time.

In a review of the call bell records in October 2016, around the time resident #002 had attempted their own care, the Inspector identified that resident #002 had initiated their call bell at 1631 hours and it was cancelled by PSW #113 at 1641 hours. The call bell was cancelled approximately 19 minutes prior to when RPN #112 found resident #002 in the bathroom alone and calling for help after they had attempted their own care.

The Inspector reviewed resident #002's care plan that was in effect at the time of the incident, which indicated that the resident required specific interventions implemented related to their activity of daily living (ADL) routines.

In an interview with Inspector #638, resident #002 stated that they sometimes had to wait for long periods of time for staff to respond to their call bell. The resident stated that they have become frustrated at times and had attempted to complete care themselves even though they required assistance.

Inspector #638 further reviewed the call bell records for resident #002. Upon review the Inspector identified that on one evening in September 2016, resident #002 had rang their bell at 2014 hours and the call was responded to 27 minutes later at 2041 hours. The Inspector also identified another date in October 2016, where resident #002 rang their call bell at 1844 hours which was responded to 49 minutes later at 1933 hours.

In an interview with Inspector #638, PSW #114 stated that when a resident were to ring their call bell to request assistance, the process was to respond to the resident "as soon as possible". The PSW then stated that if they were busy, they would at least have laid their eyes on the resident to ensure their safety or request another staff member attend to the resident's needs. PSW #114 stated that it would not be reasonable if a call bell was ringing for over 20 minutes without a staff member checking on the resident to determine their safety.

The home's policy titled "Nurse Call System" last revised April 29, 2016, indicated that staff would respond to the resident's room in a timely manner. The policy also indicated that staff would report to the resident's room as soon as possible to attend to the resident's needs.

In an interview with Inspector #638, the ADOC stated that staff should check resident needs and request assistance if care needs were not being met in a timely manner. The ADOC then stated that it was unacceptable that resident #002 waited so long and they would expect that staff assisted residents in a timely manner. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #002's right to be properly cared for in a manner consistent with their needs are fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviours plan of care was based on, at minimum, an interdisciplinary assessment of the following with respect to the resident, any mood and behaviour patterns, including wandering, any identified responsive behaviours, and behavioural triggers and variations in the resident's functions at different times of the day.

Four complaints with three CIS reports attached were submitted to the Director related to multiple incidents of resident to resident abuse. The complaints identified multiple incidents where resident #001 had displayed responsive behaviours towards other residents in the home and that the home had not been effectively managing resident #001's behaviours.

Inspector #638 reviewed resident #001's progress notes over a 28 day period in 2017, which identified that the resident had demonstrated responsive behaviours towards residents and staff on 11 of the 28 days or 40 per cent of the time.

In a review of the Minimum Data Set (MDS) assessment completed on resident #001, the

Inspector identified that the resident was assessed demonstrating specific behavioural symptoms between one and three days out of the seven day assessment period.

The Inspector reviewed resident #001’s care plan and was unable to identify any; foci, goals or interventions related to resident #001's assessed responsive behaviour, to direct staff to respond appropriately to the resident’s specific responsive behaviour.

In an interview with Inspector #638, PSW #101 stated that resident #001 had been known to demonstrate specific responsive behaviours during periods of escalation, especially towards other residents. The PSW also stated that they used a set of specific interventions when the resident became responsive.

Inspector #638 interviewed PSW #103 and #104. They both stated that resident #001 commonly displayed specific responsive behaviours. Both PSWs stated that they would have expected that the resident’s care plan would have identified the types of behaviours a resident was known to exhibit.

During an interview with Inspector #638, RN #102 stated that registered staff were in charge of ensuring that a resident’s care plan was kept up to date. The RN then stated that any type of responsive behaviour demonstrated should be identified in the resident’s care plan in order to ensure staff were kept aware of resident specific behaviours and the appropriate interventions when the resident became triggered.

The home’s policy titled “Responsive Behaviours” last revised June 6, 2016, indicated that the resident who demonstrated responsive behaviours’ care plan would identify; strategies to eliminate triggers, minimize behaviours and how staff would respond effectively.

In an interview with Inspector #638, the ADOC stated that the resident's care plan should represent any type of behaviour a resident has exhibited. The ADOC reviewed resident #001’s care plan with the Inspector and was unable to identify any focus on this specific responsive behaviours for the resident. The ADOC stated that when a resident demonstrated certain behaviours, it was required that staff included this in the resident’s care plan. [s. 26. (3) 5.]

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 responsive behaviours plan of care is based on an interdisciplinary assessment of the residents which includes, any mood and behaviour patterns, including wandering, any identified responsive behaviour, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours.

Three complaints submitted to the Director related to multiple incidents of alleged resident to resident abuse. The complaint identified multiple incidents where resident #001 displayed responsive behaviours towards resident #002. The complaint further identified that resident #002 as a result of the incidents, began displaying specific responsive behaviours.

Inspector #638 reviewed resident #002's progress notes, which identified that the

resident had displayed specific responsive behaviours. The progress notes further identified that resident #002 told staff that they become upset in certain circumstances and this caused them to display responsive behaviours.

In an interview with Inspector #638, resident #002 stated that as a result of the incident with resident #001 they had been displaying responsive behaviours. The resident then stated that the interventions implemented in response to other residents' responsive behaviours were not effective. The resident stated that they often displayed responsive behaviours in specific circumstances.

In an interview with Inspector #638, PSW #106 stated that resident #002 was known for becoming behavioural when residents displayed specific behaviours.

Inspector #638 conducted an interview with RPN #107, who stated that resident #002 was well known for displaying specific behavioural symptoms. The RPN then stated that one of resident #002’s triggers for their behaviours was related to other resident's specific responsive behaviours.

Inspector #638 reviewed resident #002’s plan of care. The Inspector was unable to locate any indication that resident #002's behaviours were triggered by specific responsive behaviours by other residents in the home.

The home’s policy titled “Responsive Behaviours” last revised June 6, 2016, indicated that the resident's care plan minimally should include behavioural triggers.

In an interview with Inspector #638, the ADOC stated that the care plan should have identified the resident specific behaviours and triggers which would have included interventions to appropriately respond to the resident’s behaviours. The ADOC then stated that they would have expected to see the triggers associated with resident #002’s assessed behaviours as well as interventions to alleviate these behaviours. [s. 53. (4) (a)]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

A complaint with a CIS report attached identified resident #001 had displayed specific

responsive behaviours towards resident #003 who was their table mate during the dining service. The complaint further identified that a couple of days later, second similar incident had occurred between resident #001 and resident #003 and the complainant felt as though nothing had been done to prevent this incident from reoccurring.

Inspector #638 reviewed resident #003's progress notes which indicated that in January 2017, during a meal service, resident #001 displayed their responsive behaviours towards resident #003. The progress notes indicated that after the incident resident #003's Substitute Decision Maker (SDM) inquired about a new seating arrangements in order to ensure resident safety, to which RPN #109 stated that they would ensure that staff would look into a solution.

The Inspector was unable to locate any documentation or action taken in response to resident #001's behaviours in order to minimize risk to the residents.

The progress notes further indicated that two days later, while still seated in the same seating arrangement, resident #001 again demonstrated responsive behaviours towards resident #003 during a meal service. The notes then indicated that the SDM was "upset" because they were informed of a similar incident two days prior and thought that staff had looked into alternative options to prevent re occurrence. The resident was then moved the following day, prior to the next meal service.

The Inspector conducted an interview with RPN #107 who stated that when seating arrangements during meal services were ineffective, the home's process could have included ensuring resident safety by moving one of the residents to a new seating arrangement. This process would have included receiving consent from the SDM, completing a referral to notify the home of the changes required and this needed to be done immediately in order to ensure resident safety.

In an interview with Inspector #638, the ADOC stated that they were unable to identify any indication that any action was taken after the first incident between resident #001 and resident #003. The ADOC then stated that the registered staff should have immediately looked into alternatives and followed the home's procedure to move the resident to a new seating arrangement prior to the next meal service as well as documented any changes or interventions implemented to minimize the risk of future incidents. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, the goals the care was intended to achieve.

Four complaints were submitted to the Director related to an incident of alleged resident to resident abuse. The complaint alleged that resident #012 had become agitated towards resident #011 and had demonstrated responsive behaviours towards resident #011, as a result of resident #011's responsive behaviours.

Inspector #638, reviewed resident #012's progress notes which identified that resident #011 had displayed a specific responsive behaviour. The progress notes identified that in response, resident #012 had displayed a specific responsive behaviour towards resident #011.

The Inspector reviewed resident #012's current care plan which did not identify that the resident had this specific type of responsive behaviour when triggered which also gave no goals related to the resident's behaviour that the care was intended to achieve.

In an interview with Inspector #638, PSW #127 stated that resident has been displaying more specific responsive behaviours lately, however, there was only one incident related to the resident displaying the type of specific responsive behaviour during the incident with resident #011. The PSW then stated that they would have expected any behaviours a resident demonstrated to be demonstrated in their care plan.

The home's policy titled "Careplanning" last revised December 6, 2016, indicated that registered staff were expected to individualize and personalize the resident's care plan to indicate their specific foci, goals and interventions.

In an interview with Inspector #638, the acting DOC stated that any behaviour should be represented within the resident's care plan. The acting DOC then stated that the care plan was required in order to inform staff regarding resident specific behaviours, triggers and interventions. [s. 6. (1) (b)]

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

Two complaints submitted to the Director related to allegations of improper care. The

complaint indicated that resident #006 was not receiving care as often as the resident required and that the resident's skin integrity was suffering as a result.

Inspector #638 reviewed resident #006's care plan which identified multiple conflicting interventions related to resident #006's specified care. Their care plan identified;

a) One of resident #006's care plan foci indicated that the resident used a specific product during the day and a different product at night, while another foci indicated that the resident used only the specific product throughout the day and night;

In a review of the "SJV 3 Day Bowel and Bladder Trial" document, the Inspector identified that the resident had been assessed as requiring a specific product during days and evenings and a different product during the night.

Inspector #638 conducted an interview with the ADOC who stated that they had recently completed a continence assessment and it had been determined that the best option for the resident was to implement the specific product throughout the day and a different product at night. The ADOC then stated that the care plan was not updated in entirety to represent the resident's assessed needs.

b) One of the resident's care plan foci indicated that the resident required a specific intervention implemented every two hours in order to prevent altered skin integrity, while another foci directed staff to implement the same specific intervention only twice a shift (once every four hours) and as needed;

Inspector #638 interviewed PSW #111 who stated that resident #006 required their specific continence care intervention at minimum every two hours and more as needed. The PSW stated that the resident was known for experiencing areas of altered skin integrity and required frequent care to manage this risk for altered skin integrity.

In an interview with Inspector #638, RPN #110 stated that resident #006 required their specific continence care interventions implemented at minimum every two hours and as needed to minimize skin integrity concerns. The RPN then stated that the resident's care plan interventions did not complement one another and required an amendment.

c) Another area of resident #006's care plan indicated that the resident was to be positioned in a certain manner and left alone after meals, while another foci in the resident's care plan identified that the resident was not to be positioned in the specified

manner if nobody remained with the resident.

During an interview, PSW #111 stated that resident #006 recently started being left positioned in a certain manner as per family request and that this intervention was implemented at specified times throughout the day.

In an interview with Inspector #638, RPN #110 stated that resident #006 had a new intervention which directed staff to position the resident in a specific manner at certain times of the day. The RPN then stated that the resident's care plan was not clear and should be amended to represent the resident's needs in a clear and consistent manner.

In an interview with the ADOC, they stated that the care interventions of a specific resident's care plan should be consistent so staff could maintain consistent care to meet the resident's assessed needs. [s. 6. (1) (c)]

3. 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.

Four complaints with three CIS reports attached were submitted to the Director related to multiple incidents of resident to resident abuse. The complaints identified multiple incidents where resident #001 had responsive behaviours towards other residents in the home and that the home had not been effectively managing resident #001's behaviours.

Inspector #638 reviewed resident #001's progress notes over a 28 day period in 2017, which identified that the resident had demonstrated specific responsive behaviours towards residents and staff on 17 of the 28 days or 60 per cent of the time.

The Inspector reviewed resident #001's care plan, which identified that staff would refer to the medication administration record (MAR) for pharmacological interventions when the resident was demonstrating signs of responsive behaviours.

In a review of the physician orders, the Inspector identified that a specific medication was ordered as needed (PRN), to manage resident #001's responsive behaviours.

Inspector #638 reviewed the MAR for resident #001 for the same 28 day period as reviewed in the progress notes, which indicated that the resident only received their pharmacological intervention for a specific responsive behaviour on four of the 17 days that the resident had demonstrated a specific responsive behaviours.

Inspector #638 conducted an interview with RPN #107, who stated that resident #001 had been frequently displayed specific responsive behaviours over the last couple of months. The RPN then stated that the resident had specific interventions implemented to manage the resident's responsive behaviours which included the implementation of pharmacological interventions for a specific responsive behaviour. The RPN stated that resident #001 should have received their ordered pharmacological interventions as per the resident's care planned interventions related to agitation any time their behaviours escalated.

In an interview with Inspector #638, RN #102 stated that their role in responding to a resident who demonstrated responsive behaviours would have been to implement care as laid out within the resident's plan, which included the administration of medications where appropriate.

The Inspector reviewed the "Timeline" documentation created by SW #105, which indicated that the home's Responsive Behaviour Team (RBT) and Behaviour Supports Ontario (BSO) met in February 2017. The assessment completed by the RBT and BSO team identified that resident #001 had not been administered their PRN medications when their behaviours had escalated as ordered by the physician.

The home's policy titled "Careplanning" last revised December 6, 2016, indicated that staff were to ensure that care was provided to the residents as it was set out within their plan.

During an interview with the Inspector, the ADOC stated that for resident #001, they were not sure why the resident did not receive their pharmacological interventions for a specific responsive behaviour aside from four of the 17 days that specific responsive behaviours were exhibited by resident #001. The ADOC then stated staff should have implemented care as laid out within the resident's plan of care, which included the implementation of pharmacological interventions when required. [s. 6. (7)]

4. A complaint was submitted to the Director which alleged resident to resident abuse. The complaint identified resident #008 was in resident #007's room while resident #007 was asleep in their bed. The complaint further indicated that resident #008 had physically abused resident #007 while they slept. The complainant stated that the interventions implemented to prevent resident #008 from wandering into resident #007's room were ineffective.

Inspector #638 reviewed resident #008's progress notes over a 31 day period in 2017, which identified that the resident had demonstrated physically responsive behaviours towards residents and staff on eight of the 31 days or 25 per cent of the time.

In a review of the resident #008's care plan, the Inspector identified that staff were to refer to the MAR for pharmacological interventions. The Inspector reviewed resident #008's physician orders, which identified that the physician ordered a specific medication to be administered as needed when resident #008 displayed specific responsive behaviours.

The Inspector reviewed resident #001's care plan which identified that staff would refer to the MAR for pharmacological interventions when the resident was demonstrating signs of behaviours.

Inspector #638, reviewed the MAR between for the same 31 day period as reviewed in the progress notes, which indicated that out of the eight days where resident #008 had demonstrated physically responsive behaviours towards staff and residents, the resident was only administered their pharmacological intervention once.

In an interview with Inspector #638, RN #102 stated that their role in responding to a resident who demonstrated responsive behaviours would have been to implement care as laid out within the resident's plan, which included the administration of medications where appropriate.

A review of the "Geriatric Psychiatry Consultation Service Referral Form", indicated that resident #008 was a risk to staff and residents due to their frequent behavioural symptoms.

During an interview with the Inspector, the ADOC stated that the specific responsive behaviour would include; any behavioural trigger that caused an escalation in the resident's behaviours. The ADOC stated that resident #008 was considered to be displaying a specific responsive behaviour, as identified in the physician order, when they displayed specific behaviours towards staff and residents, when the resident's behaviours escalate and when resident safety was at risk due to the resident's behaviours. The ADOC then stated staff should have implemented care as laid out within the resident's plan of care, especially when a resident was at risk of harming themselves or others within the home. [s. 6. (7)]

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

A complaint was submitted to the Director related to nutritional supplements not being administered as it had been ordered. The complaint indicated that resident #011 was ordered a nutritional supplement at prescribed times during the day and staff were not providing the supplement as it was ordered to the resident.

In a review of resident #011's care plan, the Inspector identified that the resident required their nutritional supplement twice daily.

The Inspector reviewed the physician orders which indicated that resident #011 was ordered a nutritional supplement twice a day in August 2016.

Inspector #638 conducted a review of the electronic MAR records for resident #011's nutritional supplement which was to be administered at specific times in December 2016, and January 2017. Through the review the Inspector identified that there was no documentation regarding the nutritional supplement for six days in December 2016, as well as five days in January 2017.

In an interview with Inspector #638, RPN #122 stated that all nutritional supplements were documented on the electronic MAR in order to indicate if the directive was provided as ordered. The RPN then stated that even if the nutritional supplement was refused or not provided, it would have been documented in the electronic MAR to notify staff if the ordered directive was provided or refused. The Inspector reviewed the electronic MAR for December 2016, and January 2017, with RPN #122 who stated that there should not have been any blank spots in the electronic MAR and that it would be difficult to determine whether the resident had received their nutritional supplement at the ordered time.

The home's policy title "The Medication Pass" - #3-6 last revised February 2017, indicated that once a medication was offered staff would document on the MAR in the proper space for each medication administered, missed or refused.

In an interview with Inspector #638, the ADOC stated that nutritional supplements documentation records were maintained within the eMAR. The ADOC then stated that when ordered the nutritional supplement was required to be signed for so staff could

easily determine if the resident had received their required nutritional supplements. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Four complaints with three CIS reports attached were submitted to the Director related to multiple incidents of resident to resident abuse. The complaints identified multiple incidents where resident #001 had demonstrated responsive behaviours towards other residents in the home and that the home had not been effectively managing resident #001's behaviours.

In a review of resident #001's progress notes, it was identified that the resident had been placed on a specific intervention to manage the resident's responsive behaviours in February 2017, after their incident of responsive behaviours with resident #002. Inspector #638, reviewed resident #001's current plan of care and it did not identify that the resident required this new specific intervention which was implemented in February 2017.

In an interview with PSW #101, they stated that resident #001 required this specific intervention to better manage the resident's responsive behaviours and to minimize their risk of escalation.

The Inspector interviewed PSW #103 who stated that resident #001 required the specific intervention to manage their increased responsive behaviours. The PSW then stated that staff were required to refer to the resident's specific plan of care in order to determine resident specific needs.

Inspector #638 conducted an interview with the acting DOC who stated that resident #001 had new interventions implemented in February 2017, to better manage their responsive behaviours, which was maintained throughout the entire inspection. They stated that a staff member was to implement this specific intervention at scripted times throughout the day to ensure that the resident's responsive behaviours were monitored and managed. The acting DOC then stated that this intervention would remain in place until their behaviours were better managed and that the resident's care plan should have been updated to include the new intervention to manage resident #001's behaviours. [s. 6. (10) (b)]

7. Two complaints submitted to the Director related to allegations of improper care. The complaint indicated that resident #006 was not receiving their specific care as often as the resident required and that the resident's skin integrity was suffering as a result.

Inspector #638 reviewed resident #006's care plan which indicated that staff were to ensure that the resident's specific intervention was implemented at all times.

The Inspector observed resident #006 on March 8, 2017, at 1145 hours. The resident's specific intervention was not implemented as per the resident's care plan.

In an interview with Inspector #638, RPN #110 stated that the specific intervention intervention was not currently being implemented due to a change in resident #006's health status. The RPN then stated that the care plan should be revised in order to demonstrate the resident's current care needs.

The home's policy titled "Careplanning" last revised December 6, 2016, indicated that staff were required to review and update the care plan with input from the resident and family as needed. The policy further identified that staff were to ensure that changes to the plan were noted, communicated and documented in the plan.

During an interview with the Inspector, the acting DOC stated that the resident specific care plan should be revised any time the resident's care needs changed. [s. 6. (10) (b)]

WN #5: 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 the resident who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

Two complaints submitted to the Director related to allegations of improper care. The complaint indicated that resident #006 was not receiving their specific care as often as the resident required and that the resident's skin integrity was negatively effected.

Inspector #638 identified through a review of resident #006’s care plan that the resident was at risk for altered skin integrity.

The Inspector reviewed the progress notes for resident #006, which indicated that the resident had exhibited an area of altered skin integrity in October 2016.

In an interview with Inspector #638, RPN #110 stated that whenever a resident exhibited altered skin integrity an initial wound assessment would have been completed. The RPN then stated that this initial assessment would have included a thorough skin and wound assessment and at minimum weekly re assessments until the area of altered skin integrity was resolved.

In a review of the completed assessments for resident #006, the Inspector was unable to identify any initial or follow up wound assessments completed after the resident had exhibited this new area of altered skin integrity in October 2016.

The home's policy titled "Wound and Skin Care Program" issue date June 14, 2013, indicated that it was the registered staffs' responsibility to complete the initial wound assessment upon discovery of the area of altered skin integrity.

In an interview with Inspector #638, the ADOC stated that the process in place in October 2016, was whenever a new instance of altered skin integrity presented registered staff were expected to complete an initial wound assessment in the assessments tab on Point Click Care (PCC). The Inspector and ADOC reviewed the completed assessments for resident #006. The ADOC was unable to locate any completed assessments related to the resident’s altered skin integrity to their perineum in October 2016. [s. 50. (2) (b) (i)]

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 casual 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 was specifically designed for assessment of incontinence.

A complaint was submitted to the Director which was related to continence products in the home. The complaint identified that there was concern regarding the fit of the resident #011's product.

In a review of resident #011's health care records, Inspector #638 identified in the progress notes in November 2016, that the resident was found with their product displaced. It was documented that PSW #118 stated to the resident at the time, that this had been happening more often lately.

In an interview with Inspector #638, PSW #119 stated that resident #011 utilized specific products during the day and night. The PSW then stated that there was a specific intervention utilized to ensure that the product remained in place. The PSW stated that a referral should have been implemented for a continence assessment anytime an incontinence product was suspected to not appropriately fit the resident.

Inspector #638 reviewed the care plan of resident #011 which identified that the resident used a specific product, different than identified by PSW #119, for continence. The resident's care plan further identified that staff were expected to implement a specific intervention to ensure the product remained in place. The Inspector then reviewed the PSW reference "Resident Worksheet" for products used by the residents. The "Resident Worksheet" identified that resident #011 required a different product than what was indicated in the care throughout all shifts.

The home's policy titled "Continence Care Program" issue date February 8, 2013, indicated that a "Bowel and Bladder Continence Assessment would have been completed on admission and upon any change that may affect continence.

In a review of the health care records, the Inspector was unable to identify a completed clinically appropriate continence assessment to identify the resident's needs, patterns and interventions regarding their incontinence around the time when the resident was found with their product displaced.

In an interview with Inspector #638, the ADOC stated that they would have expected that a full continence assessment would have been completed when a resident's product was displaced, in order to ensure that the resident was wearing the appropriate sized product. The ADOC identified that the resident's care plan and "Resident Worksheet" conflicted and did not provide clear direction and the ADOC was unable to provide the Inspector with any documentation indicating that a continence assessment had been completed on resident #011 which would have identified resident #011's specific needs. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home which included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to have been taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Four complaints were submitted to the Director which were related to various complaints that were brought forward to the home. The complainant felt as though the home did not respond to their complaints appropriately or deal with their concerns in a timely manner.

In a review of resident #011's progress notes, Inspector #638 identified that in January 2017, resident #011's family brought forward a complaint related to the resident's mobility device not functioning properly. The progress notes further identified that family went to the DOC on another date in January 2017, and complained regarding staff attitudes in the home.

The home's policy titled "Complaints, Concerns, and Suggestions Process" last revised March 15, 2016, indicated that for every verbal complaint that was not resolved within 24 hours, the home will maintain a record of each complaint received which included; the nature of the complaint, the date the complaint was received, the actions taken to resolve the complaint, the final resolution, every date a response was provided to the complainant and any subsequent responses made by the complainant.

Inspector #638 requested specific documentation related to various complaints that the family of resident #011 had lodged to the home on March 16, 2017. The Administrator was unable to provide the Inspector with any documentation regarding the complaints that the family of resident #011 had lodged, which would have included actions and outcomes taken by the home. The Administrator stated that whenever there was a complaint the home required documentation be kept of the events and resolutions surrounding the complaint. [s. 101. (2)]

Issued on this 31st day of March, 2017

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

Original report signed by the inspector.