Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/GeNR/RCe d'inspection**
July 3 to July 6, 2012 (onsite)	2012_ 2792_198_00008	Other-Data Quality Inspection (Restorative Care and Therapies)

Licensee/Titulaire
Toronto Finnish-Canadian Seniors Centre
795 Eglinton Avenue East
Toronto, ON M4G 4E4
Fax : 416-425-6319

Long-Term Care Home/Foyer de soins de longue durée
Suomi-Koti Toronto Nursing Home
795 Eglinton Avenue East
Toronto, ON M4G 4E4
Tel: 416-425-4134
Fax: 416-425-6319

Name of Inspector(s)/Nom de l'inspecteur(s)
Patricia Ordowich (198) (lead)
Mary Sotirakopoulos (201)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Data Quality inspection related to restorative care and therapies.

During the course of the inspection, the inspectors spoke with: Administrator, Restorative Care Lead/RAI Co-ordinator, Physiotherapist, Physiotherapy Assistant, Restorative Care Aide, Office Co-ordinator, and Nursing Consultant.

During the course of the inspection, the inspectors reviewed: resident health records for 10 residents in the home for the quarters from July 1, 2010 to March 31, 2011 submitted to the Canadian Institute for Health Information (CIHI) (January 1, 2012 to March 31, 2012) for those residents who still lived in the home, applicable home policies and procedures; and the Physiotherapy contracted services guidelines (2012).
The following Inspection Protocol was used in part or in whole during this inspection: Restorative Care and Therapy.

☒ Findings of Non-Compliance were found during this inspection.

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NON- COMPLIANCE / (Non-respectés)

The following are some of the definitions that may have been used in this report:

AROM = active range of motion
CIHI = Canadian Institute for Health Information
HSP = Health Service Provider
LHSIA = *Local Health Systems Integration Act*
L-SAA = LHIN-Service Accountability Agreement
LTCHA = *Long-Term Care Homes Act, 2007*
NR/RC = Nursing Rehabilitation/Restorative Care
PROM = passive range of motion
PT = Physiotherapy
RAI-MDS 2.0 = Resident Assessment Instrument-Minimum Data Set 2.0
RAPs = Resident Assessment Protocols
VPC = Voluntary Plan of Correction/Plan de redressement volontaire
WN = Written Notice

Q2 = July 1 to September 30, 2010
Q3 = October 1 to December 31, 2010
Q4 = January 1 to March 31, 2011
Most recent quarter inspected = January 1, 2012 to March 31, 2012

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *Long Term Care Homes Act (LTCHA), 2007*, c. 8, s. 101.

(1) A licence is subject to the conditions, if any, that are provided for in the regulations. 2007, c. 8, s. 101.

(2) The Director may make a licence subject to conditions other than those provided for in the regulations,

(a) at the time a licence is issued, with or without the consent of the licensee; or

(b) at the time a licence is reissued under section 105, with or without the consent of the new licensee. 2007, c. 8, s. 101 (2).

(3) It is a condition of every licence that the licensee shall comply with this Act, the *Local Health System Integration Act, 2006*, the *Commitment to the Future of Medicare Act, 2004*, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

(4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101 (4);

Findings:
Findings:

1. The Long-Term Care Homes Service Accountability Agreement (L-SAA) is an agreement entered into between the local health integration network and the Licensee, Toronto Finnish-Canadian Seniors Centre, under the *Local Health System Integration Act, 2006*. Compliance with the L-SAA is, therefore, a condition of the license issued to Toronto Finnish-Canadian Seniors Centre, for the Suomi-Koti Toronto Nursing Home.
2. The Licensee has failed to comply with the following provisions of the L-SAA:

Article 3.1

(a) The HSP will provide the Services in accordance with:

(i) this Agreement;

(ii) Applicable Law; and
(iii) Applicable Policy.

Article 8.1

(a) The LHIN's ability to enable its local health system to provide appropriate, co-ordinated, effective and efficient health services as contemplated by LHSIA, is heavily dependent on the timely collection and analysis of accurate information. The Health Service Provider (HSP) acknowledges that the timely provision of accurate information related to the HSP is under the HSP's control;

Article 8.1(b): The HSP [Health Service Provider]

(iv) will ensure that all information is complete, accurate, provided in a timely manner and in a form satisfactory to the LHIN [Local Health Integration Network];

Article 8.1 (c): The HSP will:

(i) conduct quarterly assessments of Residents, and all other assessments of Residents required under the Act, using a standardized Resident Assessment Instrument - Minimum Data Set (RAI-MDS 2.0) 2.0 tool in accordance with the RAI-MDS 2.0 Practice Requirements included in Schedule F and will submit RAI-MDS 2.0 assessment data to the Canadian Institute for Health Information (CIHI) in an electronic format at least quarterly in accordance with the submission guidelines set out by CIHI; and

(ii) have systems in place to regularly monitor and evaluate the RAI-MDS 2.0 data quality and accuracy;

3. The RAI-MDS 2.0 LTC Homes – Practice Requirements are included in Schedule F of the L-SAA and fall within the definition of "Applicable Policy" under the L-SAA.
4. The RAI-MDS 2.0 Agreement between the Minister of Health and Long-Term Care and the Licensee, Toronto Finnish-Canadian Seniors Centre, is an agreement under the *Long-Term Care Homes Act, 2007* for the provision of funding related to the implementation of RAI-MDS 2.0 assessment tool in long-term care homes. Compliance with the RAI-MDS 2.0 Agreement is, therefore, a condition of the license issued to Toronto Finnish-Canadian Seniors Centre for the Suomi-Koti Toronto Nursing Home.
5. The documents listed in Schedules A to E of the RAI-MDS 2.0 Agreement between the Licensee, Toronto Finnish-Canadian Seniors Centre and the Ministry of Health and Long-Term Care fall within the definition of "Applicable Policy" in the L-SAA. These documents include, but are not limited to, the Sustainability Project Description, the Implementation Information Package together with the Training Module Overview, and the RAI Coordinator Role Description.
6. The level-of-care per diem funding in the Nursing and Personal Care (NPC) envelope paid by the local health integration network to the Licensee pursuant to the L-SAA is adjusted based on resident acuity. The higher the acuity, the greater the funding. The amount of funding in the NPC envelope is calculated using a formula set out in the LTCH Level-Of-Care Per Diem Funding Policy (a policy listed in Schedule F of the L-SAA) and resident acuity is determined using the RAI-MDS 2.0 information submitted by the Licensee to CIHI.
7. The incompleteness and inaccuracy of the RAI-MDS 2.0 data is evidenced by the following:
   (a) The RAI-MDS 2.0 coding was not supported by the home's documentation, including the residents' plans of care and the RAPs documentation. There were multiple inconsistencies between what was coded on the RAI-MDS 2.0 and the progress notes found in the residents' plans of care.
8. The following are specific examples of incomplete and/or inaccurate RAI-MDS 2.0 coding and non-compliance with the L-SAA and/or the RAI-MDS 2.0 LTC Homes – Practice Requirements and/or the Implementation Information Package and/or the RAI Coordinator Role Description and/or the RAI-MDS 2.0 Agreement. The RAI-MDS 2.0 Practice Requirements mandates the use of the RAI-MDS 2.0 Manual, which states that a rehabilitation or restorative practice must meet specific criteria including that measureable objectives and interventions must be documented in the care plan and in the clinical record.

a. Resident 001:
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received AROM and PROM NR/RC activities. However, there was no plan of care for these NR/RC activities.
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation for PT. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 45 minutes, however no activity log was provided and the documentation indicated that the resident was ill during the 7-day observation period. It was unclear how often the resident attended during the observation period.

b. Resident 002:
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received AROM, PROM and walking NR/RC activities for 7 days of the observation period. However, there was no plan of care for these NR/RC activities.

c. Resident 003:
   - There were discrepancies within the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident was totally incontinent of bowel and bladder, however the resident was also coded as being on a scheduled toileting plan. For the purposes of RAI- MDS 2.0 coding, a toileting plan is used for continent residents. If the resident is routinely taken to the toilet at scheduled times but the resident does not eliminate in the toilet and the resident is still incontinent, this is not a toileting plan.
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation for PT. The resident was coded on the RAI-MDS 2.0 as receiving 3 days of physiotherapy for a total of 45 minutes. However, the PT activity log indicated that the resident received 2 days of PT for a total of 46 minutes.

d. Resident 004:
   - There was a discrepancy within the coding of the RAI-MDS 2.0. The RAI-MDS 2.0 was coded for the NR/RC walking activity however the RAI-MDS 2.0 was also coded that the resident did not walk in room and corridor during the observation period. Therefore this did not meet the RAI-MDS 2.0 definition for a NR/RC walking activity as the resident was not ambulatory.
   - There was a discrepancy between the coding of the RAI-MDS and the documentation for PT. The resident was coded on the RAI-MDS 2.0 as receiving 3 days of physiotherapy for a total of 45 minutes. However, the PT activity log indicated that the resident received 4 days of PT and there were no minutes documented. It was unclear how often the resident attended as well as the length of time of attendance during the observation period.

e. Resident 005:
   - There were discrepancies within the coding of the RAI-MDS 2.0. The RAI-MDS 2.0 was coded for AROM and PROM NR/RC activities, however the RAI-MDS 2.0 was also coded that the resident had no limitations in functional range of motion in any joints. The plan of care was not provided and staff in the home indicated that the software vendor indicated that the plans of care were not archived when the home moved to the newer version of the software. Therefore, it was unclear why AROM and PROM NR/RC activities were provided when the resident did not have any functional limitations in range of motion of joints and limbs.

f. Resident 006:
   - There are discrepancies between the coding of the RAI-MDS 2.0 and the documentation including the plan of care. The RAI-MDS 2.0 was coded for 7 days for the NR/RC eating activity. However, the NR/RC flow sheets and the plan of care indicated that the resident required total feeding by 1 staff for eating. If a resident is totally dependent on staff for eating or swallowing despite all attempts to have the resident achieve or maintain self-performance in those activities, this is not considered a NR/RC eating or swallowing activity as per the RAI-MDS 2.0 coding rules.
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation for PT.

The resident was coded on the RAI-MDS 2.0 as receiving 3 days of physiotherapy for a total of 45 minutes. However, the PT activity log indicated that the resident received 1 day of PT for a total of 15 minutes.

g. Resident 007:
   - There are discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded for 7 days for the NR/RC eating activity. However, the NR/RC flow sheets indicated that the resident was a total feed of 1 staff for eating. If a resident is totally dependent on staff for eating or swallowing despite all attempts to have the resident achieve or maintain self-performance in those activities, this is not considered a NR/RC eating or swallowing activity as per the RAI-MDS 2.0 coding rules.
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation for PT. The resident was coded on the RAI-MDS 2.0 as receiving 3 days of physiotherapy for a total of 45 minutes. However, the PT activity log indicated that the resident received 2 days of PT for a total of 30 minutes.

h. Resident 008:
   - There was a discrepancy between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded for 7 days for the NR/RC transfer activity. However, the plan of care indicated to encourage resident to request assistance with transfers. This did not meet the RAI-MDS 2.0 definition for a transfer NR/RC activity as it must improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation for PT. The resident was coded on the RAI-MDS 2.0 as receiving 3 days of physiotherapy for a total of 45 minutes. However, the PT activity log indicated that the resident received 2 days of PT for a total of 40 minutes.

i. Resident 009:
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident received 7 days of NR/RC transfer activity. However, the RAPs documented that the resident refused assistance with transfers. This did not meet the RAI-MDS 2.0 definition for a transfer NR/RC activity is that it must improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. The documentation indicated that the resident refused assistance with transfers.
   - There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received 7 days of NR/RC walking activity, however the RAI-MDS 2.0 was also coded that the resident was ambulatory in room and corridor and the plan of care said that walking was supervised by staff. There was no documentation to indicate the reason for the walking program as the resident was already ambulatory. Therefore this did not meet the RAI-MDS 2.0 definition for the walking NR/RC activity as it must improve or maintain the resident's self-performance in walking, with or without assistive devices.

j. Resident 010:
   - There was a discrepancy between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded that the resident received 7 days of NR/RC PROM activity. However, the plan of care said to encourage resident to attend PT exercise program, therefore the PROM was provided by PT and not NR/RC. The RAI-MDS 2.0 Manual defines NR/RC as nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists.
   - The RAI-MDS 2.0 Practice Requirements states that for quarterly and significant change in status assessments that do not take the place of the full annual assessment, the standard statement may be used for 'existing' triggered RAPs that have no clinical and/or care plan changes. The standard

RAPs statement was used for the full annual assessment for this resident and full RAPs review was required as per RAI-MDS 2.0 Practice Requirements.	
Inspector ID #:	198, 201
Voluntary Plan of Correction (VPC) - Pursuant to the Long Term Care Homes Act (LTCHA), 2007, c.8, s.101, the licensee is hereby requested to prepare a written plan of corrective action to ensure compliance with the RAI-MDS 2.0 Long Term Care Homes Practice Requirements, to be implemented voluntarily.	

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Pat Dicdowick
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). August 22, 2012