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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 8, 2018	2018_420643_0008	008138-18	Resident Quality Inspection

Licensee/Titulaire de permis

Tyndall Seniors Village Inc.
108 Jensen Road LONDON ON N5V 5A4

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

Tyndall Nursing Home
1060 Eglinton Avenue East MISSISSAUGA ON L4W 1K3

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

ADAM DICKEY (643), MATTHEW CHIU (565), THERESA BERDOE-YOUNG (596)

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): April 25-27, 30, May 1-4, 7-11, and 14-17, 2018.

The following Critical Incident System (CIS) report intakes were inspected concurrently with this RQI:
Log #028981-17; CIS #2656-000056-17 - related to improper treatment, and
Log #000774-18; CIS 2656-000002-18, Log #002228-18; CIS #2656-000005-18, and 009107-18; CIS #2656-000013-18 - related to falls prevention and management.

The following complaint intakes were inspected concurrently with this RQI:
Log #004818-18 - related to falls prevention and management and alleged neglect,
Log #008024-18 - related to pain management, falls prevention and management and alleged neglect, and
Log #008213-18 - related to personal care and laundry service.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RN), Nurse Managers (NM), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Food Service Managers (FSM), Personal Support Workers (PSW), Housekeeping Aides (HA), Maintenance staff, Recreation Aides, Hairdresser, Residents' Council and Family Council Representatives, residents and family members.

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

Inspectors #699 Praveena Sittampalam, #727 Joanna White and #698 Oraldeen Brown attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on the needs and preferences of the resident.

During stage two of the Resident Quality Inspection (RQI) resident #012 was triggered for no oral hygiene assistance from resident interview during stage one. Resident #012 additionally triggered for oral/dental problems from the most recent full Minimum Data Set (MDS) data.

Review of resident #012's health records revealed they had been admitted to the home with identified medical diagnoses. Resident #012's Cognitive Performance Scale (CPS) score indicated they had impaired cognition.

In an interview during stage one, resident #012 stated that they only received assistance with cleaning teeth once daily in the morning. In a subsequent interview during stage two, resident #012 stated PSW staff assisted them with set-up and they were able to complete the task of brushing their teeth themselves. Resident #012 indicated that they brushed their teeth only once per day and that was their preference.

Review of resident #012's current plan of care accessed revealed they required set-up help twice daily from staff and was able to perform oral care. Goal of the plan of care was to maintain independence in mouth care twice daily. Review of point of care (POC) look back report for the mouth care task for an identified one month period revealed resident #012 had refused mouth care in the evening 16 times.

In an interview, PSW #124 stated resident #012 did not allow the staff to provide oral care and would be encouraged but would refuse most times on an identified shift. PSW #124 stated that if resident #012 was refusing to perform mouth care they would have to re-approach and if refusing more than once tell the charge nurse and document the refusal on POC.

In an interview RPN #114 stated that resident #012 was able to brush their own teeth with set-up from staff. RPN #114 indicated that they had not been aware that resident #012 had been refusing mouth care on the above mentioned identified shift. RPN #114 stated that PSW staff should let the registered staff know if a resident was refusing so that they could document in the progress notes.

In an interview, Assistant Director of Care (ADOC) #122 stated it was the expectation of the home for mouth care to be provided to residents twice daily in the morning and at bedtime unless more frequent care was required. ADOC #122 stated that it was the expectation of the home that if a resident was refusing to perform mouth care the PSW should report to registered staff and strategies could be discussed to manage the refusal. ADOC #122 acknowledged that resident #012's plan of care did not reflect the refusal to perform mouth care on the identified shift and was not based on the needs and preferences of the resident. [s. 6. (2)]

2. 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.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC), in which the complainant indicated that resident #010 was not receiving proper hygiene and grooming care.

An interview with resident #010's family member revealed the resident required assistance with showering. On an identified date, the family member was told by the primary PSW #134 that they had not assisted the resident with a specified care task during showers.

Review of resident #010's RAI-MDS assessment and plan of care revealed the resident had both cognitive and physical impairment. The plan of care indicated staff should perform the above mentioned specified care task during shower days as per family's request. If the resident refuses, the PSW should report it to the charge nurse, document and inform the family.

Review of resident #010's documentation survey report and progress notes over an identified three month period, indicated that PSW #010 had provided resident #010 assistance with showering on 16 occasions, and no records were found which indicated the resident refused assistance with the above mentioned care task.

During the course of this inspection, PSW #134 was unavailable for interview.

Interview with PSW #133 indicated that resident #010 had a history of refusing the specified care task during showers. PSW #133 indicated that if it happened, they would report the refusal to the charge nurse.

Interviews with RPN #125 revealed resident #010's family had raised concerns about the resident's hygiene on the above mentioned identified date. RPN #125 spoke with PSW #134 and was told that the resident always refused the above mentioned specified care task. RPN #125 further stated PSW #134 had never reported the refusal to them, and if the resident refused, the PSW should try again later. If unsuccessful, the staff would inform the resident's family and document.

Interview with Nurse Manager (NM) #116 indicated they were aware of the above mentioned family concerns and had no recollection of PSW #134 had ever reported the refusals until the above mentioned identified date.

Interview with the DOC indicated when they followed up with PSW #134, the PSW stated they did not perform the specified care task because the resident refused. The DOC further stated the plan of care directs the PSW to report to the charge nurse if the resident refused the specified care task. The DOC confirmed PSW #134 did not perform the specified care task nor report any refusals as specified in the plan of care. [s. 6. (7)]

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

During stage two of the RQI, resident #016 was triggered for impaired skin integrity from the past to most recent MDS assessment data.

Record review of the resident physician's orders from an identified date, indicated a treatment order for an area of impaired skin integrity. There was a specified treatment oder in place and the treatment was to be carried out on three specified days each week and as needed (PRN).

Record review of resident #016's electronic treatment administration record (eTAR) for an identified month, did not include staff sign-offs for four identified dates.

Interview with RN #116 indicated that they had completed the specified treatment order as well as the weekly assessments, but had forgotten to sign off on the TAR.

Interview with the DOC indicated the home's expectation is that once treatment orders are completed for residents' sign off should be done on the eTAR. [s. 6. (9) 1.]

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

During stage two of the RQI resident #013 was triggered for impaired skin integrity from staff interview and census record review in stage one.

Record review of resident #013's written plan of care indicated that the resident had an identified area of impaired skin integrity. Interventions to promote healing included repositioning the resident every two hours and PRN.

Review of the resident's turning and repositioning documentation indicated that for an

identified date, documentation from one shift was not completed.

Interview with PSW #119 from an agency who cared for the resident on the above mentioned identified date, reported that they repositioned the resident every two hours, but forgot to document the care.

Interview with the DOC stated that the home's expectation is that PSW staff should document at all times when residents' are repositioned related to impaired skin integrity, no matter if they are from the agency or not; in this instance PSW #119 did not document the provision of care. [s. 6. (9) 1.]

5. The licensee has failed to ensure that the plan of care was revised at any other time when care set out in the plan has not been effective.

A Critical Incident System (CIS) report was submitted to the MOHLTC which indicated resident #050 had a fall attempting to stand on an identified date. The resident sustained injury, and was sent to the hospital on the same day for medical interventions.

Review of resident #050's RAI-MDS assessment and plan of care revealed the resident had physical and cognitive impairment. The resident required one-person physical assistance for transfer and was at risk for falls.

Review of the resident #050's progress notes and post-fall assessments from the four month period leading up to the above mentioned fall, revealed they had five fall incidents during the period prior to the above mentioned date. In each instance the resident was attempting to stand and had fallen, with specified minor injuries

Further review of resident #050's falls prevention plan of care revealed specified interventions were put in place for the resident prior to a review three weeks prior to the above mentioned identified date. The goal for the plan of care was that the resident will be free from falls and injury.

On the date of the above mentioned review, the falls prevention plan of care was revised to include a specified intervention to minimize injury from a fall.

Interviews with PSW #150, RPNs #114 and #125 indicated the resident was at risk for falls and the resident would attempt to stand, self-transfer and was unsteady on their feet. The staff members indicated the falls prevention interventions were put in place for

the resident but the resident continued to fall as mentioned above. RPN #114 further stated the falls prevention plan of care might work for some residents but they were ineffective in preventing resident #050 from falling. RPN #125 indicated the interventions might reduce the number of falls but they were unable to prevent the resident from falling and sustaining injuries from the falls. PSW #150 and RPN #125 stated the falls prevention plan of care had not been revised between the above mentioned review and 12 days following the date of the identified fall in the CIS report.

Interviews with NM #116 indicated the falls prevention plan of care was able to prevent some falls but the resident kept falling. The plan of care was ineffective to free the resident from falls and injuries. NM #116 further stated during the above mentioned period, the last revision of the plan of care happened on the above mentioned date, and the resident had three fall incidents prior to the next review.

During the course of the inspection, resident #050 fell two additional times and sustained injury from one of the falls.

Interview with the DOC indicated that since the resident continued to fall and sustained injuries from the falls, the falls prevention plan of care was ineffective to keep the resident free from falls and injuries. The DOC further confirmed they expect the care to be revised when it had not been effective, but it was not. [s. 6. (10) (c)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care revised because care set out in the plan had not been effective, and different approaches had not been considered in the revision of the plan of care.

A complaint was submitted to the MOHLTC regarding falls prevention for resident #036.

During interview the complainant expressed concern that resident #036 had fallen a few times and the last time they ended up in hospital with specified injuries as a result of the fall.

Record review of resident #036's last two fall risk assessments indicated that the resident was at risk for falls.

Record review of the resident's post falls assessments revealed that the resident sustained three falls over a four month period. Review of post falls huddle notes revealed that resident #036 had an unwitnessed fall on an identified date, and was found by staff

lying on the floor in their room. The resident stated that they went to the washroom and came back but couldn't see and fell. The resident sustained specified injuries, and was transferred to hospital for assessment.

Review of the progress notes indicated that the resident returned to the home the same day as the above mentioned fall incident, then was transferred back to hospital again later that day for specified symptoms. The resident returned to the home one week later, voiced complaints of pain two days following their return, and was transferred back to hospital on the following day. The resident returned to the home on two weeks later after receiving medical interventions for specified injuries.

Interview with PSW #152 indicated that they worked the on a specified shift on the above mentioned identified date, and while completing rounds at an identified time heard resident #036 calling for help from their room. Upon attending at the resident's room they found them lying on the floor with signs of injury after falling. PSW #152 stated that the resident would usually call for assistance with toileting, but didn't use the call bell at the time of this fall.

Record review of resident #036's written plan of care indicated a goal that the resident would be free from falls through the next review. A specified falls intervention was initiated after the resident's first fall. Falls risk interventions were not added to the plan of care after the resident's second fall. Different approaches were not considered nor was the plan updated, until after the resident's third fall, when new specified falls interventions were added.

Interviews with the ADOC and RN #154 reported that different approaches should have been considered and additional specified falls risk interventions could have been added to the resident's written plan of care sooner, these interventions were considered and added to the plan of care only after the resident had sustained the third fall in the identified time period. [s. 6. (11) (b)]

7. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when it was being revised because care set out in the plan had not been effective.

During stage two of the RQI resident #010 was triggered for a fall in the last 30 days from staff interview in stage one.

Review of resident #010's RAI-MDS assessment and plan of care revealed the resident had both cognitive and physical impairment. The plan of care and post-fall assessments indicated the resident was at risks for falls and the resident had attempted unsafe self-transferring which contributed to the resident's risk for falls. The resident's plan of care indicated interventions were put in place for the resident's falls prevention and they include the use of a specified intervention which was implemented for approximately six months. On an identified date, the progress notes stated the specified intervention was discontinued because it was ineffective and the plan of care was revised accordingly.

Further review of the plan of care revealed there was no consideration of different approaches at the time of this revision on the above mentioned identified date.

Interviews with PSWs #133 and #137 indicated the resident was at risk for falls. PSW #137 further stated the resident used to have the above mentioned specified intervention in place but it had been discontinued. Interviews with RPN #125 and Nurse Manager (NM) #116 indicated when the resident started using a specified ambulation aid, the above mentioned intervention was implemented. Since the resident did not like the intervention and might remove it, the intervention was not effective preventing their falls, and therefore it was discontinued and the plan of care was revised on the above mentioned identified date. The staff further stated the team had been considering the use of alternative fall interventions for the resident after the plan of care was revised. The staff confirmed they had not considered different approach at the time of the revision.

Interview with the DOC indicated if the resident's plan of care is revised due to the care set out has not been effective, staff should consider different approach during the revision. The DOC confirmed the falls prevention plan of care was revised on the above mentioned date, because the intervention had not been effective and staff had not considered different approaches during the revision, as required. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure:
- that the care set out in the plan of care is provided to residents as specified in the plan;
- that the resident is reassessed and the plan of care revised when care set out in the plan has not been effective; and
- that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During stage two of the RQI accommodation services - housekeeping was triggered from family interview with family member of resident #009, and from resident interviews with resident #006, and #012.

Observations by the inspector on an identified date, revealed the following:

- in an identified resident room the floor surface was observed to be dusty, with a small ball of hair and string of beads on the floor near the resident bed;
- identified resident lounge area the sink counter top had food spill dried on the right side of sink;
- food debris on floor outside an identified resident room;
- in an identified resident lounge, sticky buildup on sink counter under hand sanitizer unit;

- food debris resembling a cracker on the floor outside of an identified resident room; and
- black substance/ buildup on floor under an identified appliance in an identified resident lounge.

In interviews, housekeeping aides (HA) #129 and #131 stated that housekeeping staff were responsible for cleaning hallway, lounge areas and resident rooms on a daily basis. HA #129 and #130 stated that the resident areas would be cleaned when residents were downstairs in the dining room for meals when possible.

In an interview Assistant Administrator (AA) #148 who was the lead for the housekeeping program in the home stated it was the expectation of the home for housekeeping staff to clean floors on resident home areas on a daily basis and whenever they are dirty. AA #148 stated that housekeeping staff were responsible for cleaning lounge areas including the sinks in the lounge areas on a daily basis. AA #148 stated that housekeeping staff were responsible for cleaning resident rooms including washrooms and floors on a daily basis.

Subsequent observations were conducted by the inspector with AA #148 approximately 6 hours following the initial observations,which included:
- in an identified resident room the floor surface was observed to be dusty, with a small ball of hair and string of beads on the floor near the resident bed;
- identified resident lounge area the sink counter top had food spill dried on the right side of sink;
- food debris on floor outside an identified resident room;
- in an identified resident lounge, sticky buildup on sink counter under hand sanitizer unit;

- food debris resembling a cracker on the floor outside of an identified resident room; and
- black substance/ buildup on floor under an identified appliance in an identified resident lounge.

In an interview, AA #148 stated it was the expectation of the home for these areas to be

kept clean and sanitary, and acknowledged that the above areas were not kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During stage two of the RQI accommodation services – maintenance was triggered related to resident #003, #004 and #005’s room observations during stage one which showed call bell panels with loose wiring protruding from the front of the panel in three identified resident rooms.

Observations in stage two by the inspector on an identified date showed in resident #005's room between two resident beds, black, yellow, green and red wires exposed from wire insulation hanging from call bell panel, approximately 1.5 inches of wiring exposed from the insulation. A telephone connection box was observed hanging from the wire. In resident #003's room, black, yellow, green and red wires exposed from wiring insulation hanging from call bell panel approximately one inch outside the insulation.

In interviews, PSWs #108, #109, #110 and RPN #101 stated when staff see a maintenance concern they will write the area of concern in the maintenance log at the nursing station and report to the charge nurse on the unit. The staff members stated that when a concern is logged in the maintenance log book the maintenance staff will address the concern and initial when addressed. PSW #110 indicated they had not reported the wiring in resident #005's room in the log book. PSW #109 indicated they had not reported the wiring in resident #003's room in the log book.

Record review of the daily maintenance log book from the second floor unit for the five months prior to inspection, did not indicate any staff member had reported the loose wiring at the call bell panels in resident #003 or #005's rooms.

In an interview five days following the initial stage two observations, Maintenance staff (MS) #126 indicated that staff members would report maintenance concerns by writing in the log book on each unit. MS #126 indicated that the wiring issue in resident #003's room had recently been reported and addressed the issue. MS #126 indicated that the wiring in resident #005's room had not been logged in the maintenance log and was not kept in a good state of repair as the telephone connection box was hanging from the call bell panel.

In an interview, the administrator indicated the expectation of the home was for staff members to log maintenance concerns in the log book on each unit and that direction has been provided to staff in mandatory education sessions. The administrator indicated that nursing staff audit the call bell systems on a regular basis and that if issues with wiring were noted they should be reported. The administrator acknowledged that the wiring in resident #005's room had not been addressed and was not maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 the home, furnishings and equipment are kept clean and sanitary; and
- that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

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

During stage two of the RQI resident #010 was triggered for a fall in the last 30 days from

staff interview in stage one.

Review of resident #010's RAI-MDS assessment and plan of care revealed the resident had both cognitive and physical impairment.

Review of resident #010's progress notes revealed the resident fell on an identified date, and the fall was not reported to staff until the resident asked for pain medication in the the following day.

Further review of progress notes, post-fall assessment and Head Injury Routine indicated the fall was unwitnessed in the resident's room after an identified meal, and was discovered by PSW #134 and Housekeeping Aide (HA) #136. As a result, the resident sustained a specified injury.

Interview with resident #010's family indicated the home notified them that the resident fell the day before. Subsequently, when the family member spoke with the DOC on the same day, they mentioned staff did not follow their protocol to report the fall.

During the course of this inspection, PSW #134 was unavailable for interview.

Interview with HA #136 indicated on the above mentioned date, HA #136 and PSW #134 were in the hallway outside resident #010's room and they heard the resident calling out for help. When the staff members went into resident's #010's room, they found the resident was sitting on the floor. HA #136 further stated PSW #134 assisted the resident to bed. HA #136 then left the resident and PSW #134, and expected PSW #134 to report the fall to the charge nurse as this is the PSW's responsibility.

Interviews with RPN #125, #135 and Nurse Manager (NM) #116 indicated PSW #134 did not report the fall to anyone and left their shift for the day. PSW #134 did not mention the fall until they were questioned by the RPNs in the following day. The staff members indicated PSW should report the fall to the charge nurse before moving the resident. The failure to report the resident's fall jeopardized the resident's health and safety.

Interview with the DOC confirmed the above mentioned fall and PSW #134 discovered the fall and transferred the resident prior to any assessment from a registered staff. The DOC further confirmed PSW #134's failure to report resident #010's fall had jeopardized the resident's health and safety, and acknowledged the resident was neglected by PSW #134. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone has occurred immediately reported the suspicion and the information which it was based on to the Director.

A CIS report was submitted to the MOHLTC on an identified date, related to resident #021 being sent to hospital following an incident which occurred two days prior, in which they were injured while being cared for by PSW #146. Resident #021 returned to the home with specified injuries. According to the CIS report resident #021 struck an identified object when PSW #146 was providing assistance dressing. The CIS report

indicated the police were contacted in relation to this incident. Review of the CIS report did not indicate suspicion of abuse of the resident.

Review of resident #021's health records revealed they were admitted to the home with identified diagnoses. Review of progress notes for resident #021 revealed that on on the date of the incident, PSW #146 reported to RPN #139 that the bed shifted when dressing the resident causing the resident to strike an item of furniture next to the bed. Resident #021 was noted to have indications of injury and was transferred to hospital due to pain and swelling. Resident #021 returned to the home the same day with specified injuries diagnosed. The progress notes indicated that the police were contacted regarding the incident two days later, as per facility policy.

In an interview, PSW #146 stated they had been alone, dressing resident #021 when the bed moved causing the PSW to shift forward and the resident struck the identified item of furniture. PSW #146 stated that resident #021 did not fall and reported right away to the nurse in charge who came in to assess the resident. PSW #146 stated that the injury looked worse than it was as the resident bruised easily. Review of the home's investigation revealed PSW #146 was terminated from their employment at the home.

In an interview the DOC stated that from the extent of the resident injury the story which was given by PSW #146 did not add up. The DOC further stated that they checked the bed system and did not move as described by PSW #146. The DOC stated that it was a decision of the home that it was some form of abuse and the staff member. The DOC further stated that it was possible that it was abuse which is why they called the police and that was the basis of the disciplinary action taken. The DOC stated it was safe to say given the evidence and that the scenario did not match that there was suspicion of abuse. The DOC stated that it was the expectation of the home to report the suspicion of abuse to the MOHLTC, and indicated that as the home reported that the police were called that the suspicion of abuse was reported.

In an interview the Administrator stated that the police were contacted because the story of the staff member did not make sense to them related to the extent of resident #021's injuries. The administrator stated that they did not believe that abuse was suspected, and that the police could possibly get the truth from the employee. The administrator stated that if abuse was suspected it would have been reflected on the CIS report.

In this case the DOC indicated that they had reasonable grounds to suspect abuse of resident #021 may have occurred. Review of the CIS report did not reveal this suspicion

and the information that it was based on had been immediately reported to the Director. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: 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.

During stage two of the RQI resident #013 was triggered for impaired skin integrity from staff interview and census record review in stage one.

Record review of resident #013's head to toe assessment from an identified date, indicated that the resident had an area of impaired skin integrity.

In an interview, RPN #101 reported that had an ongoing area of impaired skin integrity. According to PSW #118 the resident had an ongoing area of impaired skin integrity which was being treated with a dressing by the registered staff daily.

Review of the resident's written plan of care directed staff to assess areas of impaired skin integrity weekly, and document findings in point click care (PCC).

Record review of the resident #013's weekly wound assessments revealed that it was not completed and documented in PCC on an identified date. A weekly assessment for resident #013 indicated the condition of the resident's ongoing area of impaired skin integrity.

Interview with RPN #140 indicated that they completed the resident's weekly assessment on the above mentioned identified date, and changed the dressing, but couldn't remember why documenting the assessment was missed.

The DOC acknowledged that documentation of the weekly wound assessment for resident #013 was not completed on the above mentioned identified date, and reported that it should have been documented in the resident's clinical record in PCC. [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 #6: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that immediate action was taken to deal with pests.

During stage two of the RQI housekeeping was triggered from resident interview and family interview during stage one. In a resident interview during stage one, resident #014 stated they saw a pest and had reported that to staff of the home. In a family interview, family member of resident #009 stated that they found a pest control device in the resident's closet.

In an interview, PSW #113 stated that they had seen a pest once in the home, and that the process in the home was to report to the charge nurse on the unit or management. In an interview PSW #130 stated the process in the home was to report sightings to the charge nurse, who would take care of reporting. In an interview, RN #111 stated that the process in the home there was a pest sighting was for the charge nurse to report to the DOC or administrator for follow-up. RN #111 stated there was no documentation only to report to management for follow-up. In an interview, RN #116 stated that they would report pest sightings to maintenance and enter the information into the maintenance log

Review of the home's pest sightings and reporting log for the licensed pest control contractor revealed that on an identified date a family member reported a pest sighting in resident #014's room. Review of service records for the pest control contractor revealed services were rendered at the home three days prior to the report and two weeks following the reported sighting. Review of the service records failed to reveal documentation of service rendered related to the sighting on the above mentioned identified date reported sighting. Review of maintenance log for the identified home area failed to reveal any reported sighting of pests on the above mentioned date.

In an interview the Administrator stated that it was the expectation of the home that staff report pest sightings or reported of sightings to the charge nurse or department manager. The Administrator stated the charge nurse would take the report to the administrator or department manager for follow-up. The administrator further stated that if a pest sighting had been reported they would have maintenance staff look into the situation and/or call the pest control company. The Administrator stated that there had been immediate action to deal with the pest sighting but could not provide documentation to demonstrate action was taken. The Administrator acknowledged that there had been no visits from the pest control contractor to address the above mentioned pest sighting. In this case the licensee failed to ensure that immediate action was taken to deal with pests. [s. 88. (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 immediate action is taken to deal with pests, to be implemented voluntarily.

WN #7: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any resident who is dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

During stage two of the RQI resident #013 was triggered for an area of impaired skin integrity from staff interview and census record review in stage one.

Record review of resident #013's written plan of care indicated that resident had an area of impaired skin integrity. Interventions to promote healing included to reposition the resident every two hours and PRN. Review of the resident's assessment from an identified date indicated the condition of the above mentioned area of impaired skin integrity.

Review of the resident's turning and repositioning documentation for a specified shift on an identified date was not completed.

Interview with PSW #120 from an agency who cared for the resident on the above mentioned identified date, stated that they did not receive a shift report that day and did not reposition the resident every two hours during her shift as the care plan directed staff to do; they were not aware that the resident needed to be repositioned, and did not complete the respective documentation.

Interview with the DOC stated that the home's expectation is that PSW staff should follow residents' plan of care no matter if they are agency staff or not, and in this instance PSW #120 did not reposition the resident every two hours. [s. 50. (2) (d)]

WN #8: 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 copies of the inspection reports from the last two years for the long term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

During the initial tour of the home the inspector reviewed postings of MOHLTC public inspection reports which were posted in the home. The review failed to reveal a posting for public inspection reports #2016_189120_0061, and 2016_449619_0013.

In an interview the administrator acknowledged that the above mentioned public inspection reports had not been posted in the home in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations. [s. 79. (3) (k)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free from corrosion.

During stage two of the RQI, accommodation services – maintenance was triggered related to common areas in disrepair from resident observations in stage one. Observations during stage one showed corroded sink drains in resident shared washrooms in two identified resident rooms.

Observations by the inspector during stage two showed in the shared washroom of

identified room A, water was dripping from the faucet, with corrosion present on the sink drain. In identified room B, the sink drain was noted to be corroded around much of it's surface.

In interviews, PSWs #108, #109, #110 and RPN #101 stated when staff see a maintenance concern they will write the area of concern in the maintenance log at the nursing station and report to the charge nurse on the unit. The staff members stated that when a concern is logged in the maintenance log book the maintenance staff will address the concern and initial when addressed. PSW #110 indicated they had not reported the sink drain corrosion in room A in the log book. PSW #109 indicated they had not reported the sink drain corrosion in room B in the log book.

Record review of the daily maintenance log book from the second floor unit from the previous four month period, did not indicate any staff member had reported the sink drains were corroded in rooms A and B.

In an interview, MS #126 indicated that staff members would report maintenance concerns by writing in the log book on each unit. MS #126 indicated that the sink drain corrosion in room B had recently been reported and they had addressed the issue. MS #126 indicated that the sink drain corrosion in room A had not been logged in the maintenance log and was not free from corrosion.

In an interview, the Administrator indicated the expectation of the home was for staff members to log maintenance concerns in the log book on each unit and that direction has been provided to staff in mandatory education sessions. The administrator indicated that procedures were developed in the home for keeping sink drains free from corrosion including regular audits of the home which include the sink drains and plumbing. The administrator indicated that as the sink drain in identified resident room A had not been kept free from corrosion that the implementation of these procedures was not in place to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free from corrosion [s. 90. (2) (d)]

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Record review of the home's medication incident binder indicated there had been 10 medication incidents identified by the home from the previous quarter. Review of a medication incident report involving resident #035 revealed that the resident did not receive two identified medications on an identified date at a specified medication administration time as prescribed. The medication incident report under the family notified section, did not include documentation of the name of the family member notified nor the date they were notified of the incident.

Interview with RN #144 stated that they made an error and did not administer the resident's scheduled medications as mentioned above, and signed off on the eMAR. They reported that they contacted the resident's POA on the above mentioned identified date, and notified them of the medication incident.

Record review of the resident's progress notes did not include documentation that resident #035's POA was notified about the medication incident that occurred on the above identified date.

Interview with the DOC revealed that they spoke with resident #035's POA who stated that they could not recall being notified about the medication incident involving resident #035 on the identified date. The DOC stated that home's expectation is that when a medication incident occurs involving a resident, the resident or POA should be notified about the incident. [s. 135. (1)]

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

Record review of the home's medication tracking log and quarterly analysis for October to December 2017, in the action plan section, indicated that a medication management inservice would be held to improve registered staff knowledge on safety of medication administration. The above mentioned medication tracking log and quarterly analysis did not include a date that it was completed.

Interview with the DOC reported that they could not remember the date the above mentioned medication tracking log and quarterly analysis for October to December 2017 was completed, and the action plan item mentioned above had not been implemented. [s. 135. (3)]

Issued on this 13th day of June, 2018

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

Original report signed by the inspector.