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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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/GeNR/RCe d'inspection
April 17 to April 20, 2012 April 23 to April 24, 2012 (onsite)	2012_2855_198_00010	Data Quality Inspection (Restorative Care and Therapies)

Licensee/Titulaire
Chartwell Master Care LP
100 Milverton Drive, Suite 700
Mississauga, ON L5R4H1

Long - Term Care Home/Foyer de soins de longue durée
Villa Forum
175 Forum Drive
Mississauga, ON L4Z 4E5

Name of Inspector(s)/Nom de l'inspecteur(s)
Pat Ordowich (198) (lead)
Nancy Rawlings (199)

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: Directors of Nursing and Personal Care (DONPC) (2), RAI Coordinator (RN), Restorative Care Co-ordinator, physiotherapist, physiotherapy assistants (2), Administrator, Nurse Manager (RN)

During the course of the inspection, the inspectors reviewed: resident health records from July 1, 2010 to March 31, 2011 and most current quarter of the RAI-MDS 2.0 that had been submitted and accepted into the CIHI data base; home policies and procedures.

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.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions that may have been used in this report.

VPC – Voluntary Plan of Correction/Plan de redressement volontaire
WN – Written Notifications/Avis écrit

ARD = assessment reference date
AROM = active range of motion
CIHI = Canadian Institute for Health Information
RAI-MDS 2.0 = Resident Assessment Instrument Minimum Data Set Version 2.0
NR/RC = Nursing Rehabilitation/Restorative Care
PROM = passive range of motion
PT = Physiotherapy
QHS = Every evening at bedtime
RAI-C = RAI Co-ordinator
RAPs = Resident Assessment Protocol

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 = October 1 to December 31, 2011

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:

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, Chartwell Master Care LP, under the *Local Health System Integration Act, 2006*. Compliance with the L-SAA is, therefore, a condition of the license issued to Chartwell Master Care LP for the Villa Forum long-term care 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, Chartwell Master Care LP, 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 Chartwell Master Care LP for the Villa Forum long-term care home.
5. The documents listed in Schedules A to E of the RAI-MDS 2.0 Agreement between the Licensee, Chartwell Master Care LP 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, documentation and the plan of care. The RAI-MDS 2.0 was coded that the resident was on a NR/RC activity of a scheduled toileting plan. The RAI-MDS 2.0 was also coded that the resident was totally incontinent of urine and this was also in the RAPs documentation. The plan of care for bowel indicated to toilet as per resident's request. For the purposes of RAI- MDS coding, a toileting plan is used for continent residents. If the resident is routinely taken to the toilet at scheduled times (and not by request) but the resident does not eliminate in the toilet and the resident is still incontinent, this is not a toileting plan.

b. Resident 002

- There were discrepancies within the coding of the RAI-MDS 2.0. 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 did not walk in room or corridor during the 7-day observation period. 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 as the resident was not ambulatory.

c. Resident 003

- There were discrepancies between the coding of the RAI-MDS 2.0, the documentation and the plan of care. The RAI-MDS 2.0 was coded that the resident received the NR/RC activity of AROM for 7-days during the observation period. However, the NR/RC flow sheet indicated that the resident attended for 6 days. The plan of care documented that the resident occasionally attends the AROM exercise program and is confused and refuses to attend.
- 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 had no limitation in functional range of motion for all limbs and was also coded that the resident received 3 days of PT for a total of 45 minutes during the observation period. However, the PT plan of care indicated that the resident was to receive ROM exercises. There was no supporting documentation for the reason or evaluation of ROM exercises given that the resident had no limitation in functional range or motion for all limbs.

d. Resident 004

- There were discrepancies between the coding of the RAI-MDS 2.0, the documentation and the plan of care. The resident was coded as receiving 3 days of PT for a total of 105 minutes during the observation period. However, the plan of care indicated that the resident was to receive PT 2 to 3 times a week and the PT progress note indicated that the resident had just returned from hospital and that PT was to resume to 3 times a week. No PT activity log was provided to indicate that the resident had received PT during the observation period.
- 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 had received the NR/RC activities of AROM and walking for 7

days of the observation period. However, the NR/RC flow sheet indicated that the resident had received those activities for 4 days of the observation period.

e. Resident 005

- There were discrepancies between the coding of the RAI-MDS 2.0. The RAI-MDS 2.0 was coded that the resident was on a NR/RC activity of a scheduled toileting plan for two quarters inspected. The RAI-MDS 2.0 was also coded that the resident was totally incontinent of bladder and bowel for the two quarters inspected. For the purposes of RAI- MDS 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 plan of care. The RAI-MDS 2.0 was coded that the resident received the NR/RC activity of bed mobility for 7 days of the observation period. However, the plan of care indicated that the resident was to be turned and repositioned every two hours and did not give clear direction to staff and others who provided direct care to the resident on the activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning self in bed.
- 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 3 days of PT for a total of 45 minutes during the 7-day observation period, however the PT activity log indicated that the resident received 2 days of PT for a total of 30 minutes.

f. Resident 006

- 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 was independent for walking in room and corridor. 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 a NR/RC walking activity as the resident was already walking independently.
- There were discrepancies within the coding of the RAI-MDS 2.0 as well as the plan of care. The RAI-MDS 2.0 was coded that the resident received 3 days of PT for a total of 45 minutes during the 7-day observation period. The plan of care indicated that PT was to provide standing balance exercises 3 times a week. However, the RAI-MDS 2.0 was also coded that the resident walked independently in room and corridor and did not have any problems with standing or gait. There was no documentation to indicate the reason for the standing balance exercises as the resident did not have any problems in this area. It was unclear for the reason for the PT activity as coded on the RAI-MDS 2.0.

g. Resident 007

- 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 was on a NR/RC activity of a scheduled toileting plan. The RAI-MDS 2.0 was also coded that the resident was totally incontinent of bladder and bowel. The plan of care indicated that the resident was not toileted. For the purposes of RAI- MDS 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 plan of care. The RAI-MDS 2.0 was coded that the resident received the NR/RC activity of PROM. However, the plan of care indicated that the resident received PROM from PT and not NR/RC.

h. Resident 008

- 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 was on a NR/RC activity of a scheduled toileting plan. The RAI-MDS 2.0 was also coded that the resident was totally incontinent of bladder and bowel. For the purposes of RAI- MDS 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.

- The RAI-MDS 2.0 Practice Requirements says 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. However, the standard RAPs statement was used for the full annual assessment for this resident.

i. Resident 009

- There were 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 that the resident received the NR/RC activity of walking for 7 days of the observation period. However, the PT progress note indicated that the resident ambulated independently using a rollator walker around the unit. The NR/RC walking program assessment documented that the resident independently initiated walking. 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 a NR/RC walking activity as the resident was already walking independently.
- 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 had no limitation in functional range of motion for all limbs and was also coded that the resident received 3 days of PT for a total of 45 minutes during the observation period. However, the PT plan of care indicated that the resident was to receive AROM strengthening exercises of the four extremities. There was no supporting documentation for the reason or evaluation of AROM exercises given that the resident had no limitation in functional range or motion for all limbs.

j. Resident 010

- There were discrepancies within the coding of the RAI-MDS 2.0 and the documentation including the plan of care. The RAI-MDS 2.0 was coded that the resident received the NR/RC activity of walking for 7 days of the observation period but the RAI-MDS 2.0 was also coded that resident did not walk in the room or corridor during the observation period. The NR/RC progress notes indicated that the resident was on the walk to dine program however the plan of care documented that the resident could not weight bear and was transferred using a hoyer lift.

Inspector ID #:	198, 199

Additional Required Actions:

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 Drdowicz
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). August 9, 2012