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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2015;	2015_265526_0012 (A1)	H-002692-15	Resident Quality Inspection

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

Ontario

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THERESA MCMILLAN (526) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Compliance Order #002 has been changed to September 18, 2015.

Issued on this 21 day of August 2015 (A1)

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

Original report signed by the inspector.

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THERESA MCMILLAN (526) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 15, 16, 17, 18, 19, 22, 23, 24, 25, and 26, 2015.

Critical Incident Inspections H-001799-15 and H-002162-15; and complaint inspection H-002049-15 were completed simultaneously during this RQI.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Food Services Manager (FSM), Director of Recreation (DR), Director of Environmental Services (DES), Neighbourhood Coordinators on all home areas, the Resident Assessment Inventory (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Personal Care Aids (PCAs), dietary aids (DAs), dietary staff, housekeeping and maintenance staff, recreation staff, residents and family members.

During the course of this inspection, inspectors toured the home; observed resident care, staff, and meal service; and reviewed policies and procedures, clinical health records,

investigative notes, meeting minutes, training and education materials.

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

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

16 WN(s)
8 VPC(s)
3 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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) Resident #203 was observed walking in socks on two different occasions. During interview, the registered staff member indicated that the resident removed shoes everyday because it was uncomfortable to wear them. The resident was to wear non-skid socks or non-skid slippers to prevent falls. The written plan of care was reviewed and did not indicate that the resident required non-skid socks or slippers as an intervention to prevent falls. The interview with the Director of Nursing Care (DNC) confirmed that the non-skid socks and slippers were not included in resident's written plan of care. (561)

B) A review of clinical documentation revealed that resident #300 had physically responsive behaviours which were triggered by co-residents entering their room and that these behaviours placed co-residents at risk of harm. Documentation further revealed that the resident was involved in four altercations with co-residents who had wandered into their room during a three month time period in 2014.

Review of clinical documentation three months before this time period, indicated that a wander guard was to be placed on the resident's door to prevent co-residents from accessing resident #300's room. Behavioural Supports Ontario (BSO) notes during the three month period noted above, indicated the wander guard remained an appropriate intervention to avoid altercations. A review of the resident's written plan of care during the time period did not include the wander guard, or any other diversional interventions, to prevent co-residents from entering resident #300's room.

An interview with the home's Assistant General Manager (AGM) revealed that it was the home's expectation that interventions related to responsive behaviours, including wander guards, would be included in the written plan of care for the resident. (503)

C) Progress notes from a day in 2015, described an altercation between resident #401 and #402 that was precipitated by resident #401 wandering into resident #402's room. Resident #402 was found by staff yelling at resident #401 to get out and resident #401 struck resident #402.

Review of resident #402's clinical assessment by Behavioural Support Ontario (BSO) indicated that the resident liked their privacy, did not like residents wandering into their room, and could exhibit responsive behaviours toward co-residents particularly if co-residents wandered into their room. BSO recommended that staff include in resident #402's plan of care that co-residents be directed away from each other to decrease the risk of conflict, the use of a wander guard and 'stop' signage or mat in front of door to deter wanderers. Review of the document the home referred to as resident #402's care plan revealed that recommendations made by BSO were not included in the written plan of care.

During this inspection, a wander guard was observed to be in place in front of resident #402's doorway, however there was no "stop" sign or mat observed. In addition, during this inspection the LTC inspector asked staff where resident #401 was located. Staff stated that the resident was wandering and they didn't know where the resident was. Resident #401 was found by the LTC inspector in an empty room belonging to a resident with whom resident #401 had an altercation several days earlier. Registered

staff verified that resident #401's wandering was not monitored consistently and staff were not always aware if resident #401 attempted to enter resident #402's room.

Interviews with direct care staff confirmed that resident #402 did not like co-residents entering their room, that resident #401 frequently wandered into co-resident's rooms and that this could lead to responsive behaviours and altercations. Registered staff reviewed resident #402's written plan of care and confirmed that it did not set out the resident's planned care according to BSO recommendations to prevent altercations between resident #402 and co-residents. (526)

D) Review of resident #403's health record and interview with registered staff confirmed that the resident had developed an alteration in skin integrity that required contact precautions and treatment in June 2015. A sign was posted on the resident's door alerting staff to the need for contact precautions and a cupboard designed to hold personal protective equipment was positioned outside of the resident's room throughout this inspection; the container was observed to be empty on June 26, 2015.

During interview, a Personal Care Aid (PCA) stated an incorrect reason for contact precautions. Inspection of the resident's written plan of care revealed no entries informing staff of the planned care for resident #403 specific to their altered skin integrity or contact precautions. The Director of Nursing Care (DNC) confirmed that the written plan of care did not set out the planned care for resident #403. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

i) Resident #108's Resident Assessment Inventory Minimum Data Set (RAI MDS) assessment completed in 2015, indicated that the resident's behavioural symptoms had worsened in five separate areas. However, the assessment indicated that their behavioural symptoms had not changed compared to their status 90 days ago during the assessment completed the previous quarter.

ii) Review of resident #108's health record indicated that they were receiving a medication over a three month time period in 2015. Resident #108's RAI MDS assessment completed at the beginning of this time period indicated that the resident had received this medication during the previous seven day assessment. However the RAI MDS completed at the end of the three month time period, indicated that the resident was not receiving the medication.

During interview, the RAI Coordinator stated that the medication that resident #108 had been receiving had been discontinued and that this was reflected in the second RAI MDS assessment of that time period. During interview, a Registered Practical Nurse (RPN) and the DNC confirmed that resident #108's behaviours had worsened since the previous assessment, and the resident continued to be administered the medication up to the end of the three month time period. The DNC confirmed that the assessments regarding resident #108's medication administration were not consistent or integrated. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff who provided direct care to a resident were aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Resident #104's written plan of care under the 'Skin Concerns' section indicated that "the resident required to be repositioned every two hours. PCA to complete and sign the repositioning sheet".

The flow sheet binder that the PCAs used to document care for resident was reviewed and the binder only contained the section called 'ADL assistance' which did not include the repositioning intervention. The PCA who provided direct care to the resident was interviewed and indicated that they were not aware that the resident required to be repositioned every two hours. The DNC confirmed that the staff had access to the entire written plan of care in resident's chart in the nursing station and were expected to be familiar with this particular intervention for resident #104 as the resident had a history of skin related issues. [s. 6. (8)]

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

Resident #104's written plan of care indicated that the resident required repositioning every two hours. The registered staff confirmed that the resident was repositioned every two hours as indicated in the plan of care.

The repositioning records for two months in 2015, were reviewed and indicated that the PCAs did not always document that the resident was repositioned every two hours. During interview, the DNC confirmed that it was the home's expectation that staff members document that the resident was repositioned every two hours and that this had not been done for resident #104. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 failed to protect residents from abuse by anyone.

A) Record review and staff interviews revealed that on an identified day in 2015, a personal support worker (PSW) heard resident #301 yelling from their room. The PSW entered the resident's room where they observed a second PSW, who was providing care to resident #301, using physical force to remove the resident's clothing which nearly resulted in the resident falling off of the toilet. The responding PSW asked if the PSW providing care required assistance, and when this was declined, left the resident's room to attend to other residents. The PSW who witnessed the incident reported the observations to the Team Leader and later checked on the resident who appeared upset.

The home's subsequent investigation found that the resident had not suffered any ill effects. The home's Human Resources policy, "Prevention of Abuse in Long-Term Care", Tab 04-06 dated November 2013, directed the Team Leader to immediately separate the resident from the alleged offender if the abuse was witnessed. Interviews with the responding PSW and the Team Leader confirmed that despite the abuse being witnessed, the PSW who was providing care to the resident, was not removed

from caring for the resident or other residents in the home. Following the home's investigation the PSW who was witnessed to be using physical force was terminated.

B) A review of clinical documentation, investigative notes, critical incident report and interviews with staff revealed that on a day in 2014, an identified Registered Practical Nurse (RPN) heard yelling from the room of resident #300, and upon responding, found a visitor in the home physically assaulting resident #401. The RPN convinced the visitor to stop what they were doing and assessed the resident. There were no reported ill effects to the resident.

Interviews with registered staff and the home area's neighbourhood coordinator revealed that the visitor had complained about resident #401 and other residents entering the room of resident #300 on previous occasions. A review of the progress notes for resident #300 revealed that the same visitor was involved in a physical altercation with resident #401 several months earlier. This was verified during interview with the registered staff who wrote the progress note about the incident.

An interview with the home's Assistant General Manager (AGM) revealed that the first incident was not documented in an internal incident report and that they were unaware that this incident had occurred; the AGM further revealed a critical incident report informing the MOHLTC Director about the first incident was not submitted. The licensee failed to protect resident #401 from abuse by a visitor to the home. Steps had not been taken following a previous known incident of abuse upon resident #401, by the visitor of resident #300 and this was followed by further abuse that occurred six months later. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used,
a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices to minimize risk to residents;
b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
c) other safety issues related to the use of bed rails were addressed, including height and latch reliability.

A) Resident #104 was observed in bed with one three quarter rail and one half rail in the up position. Review of health records indicated that there was no assessment completed for the use of bed rails. The "Bed Entrapment Audit" sheet dated September 25, 2014, indicated that the bed failed the zones of entrapment in zones 2 and 4.

B) Resident #106 was observed during this inspection to have one three quarter rail applied while resident was in bed. The health records were reviewed and indicated that the resident was not assessed for the use of the bed rail. The registered staff and the DNC confirmed that the resident was not assessed for the use of the bed rail. The bed entrapment audit that was completed in September 2014, indicated that this resident's bed failed the zones of entrapment in zones 2 and 4. The three quarter rail on resident's bed was noted to be wiggling.

C) During this inspection, the Long Term Care Homes (LTC) Inspector observed the

Director of Recreation removing resident #200's three quarter bed rail from their bed system. Resident #200 had two three quarter bed rails on the bed. The Director of Recreation indicated that the resident did not require two full rails (the home identified them as full rails). The Director of Recreation indicated that upon resident's admission in 2015, the home did not remove two full rails from their bed and that the resident only required one full rail and one half rail on the opposite side while in bed. The health records were reviewed and indicated that the resident was not assessed for the use of bed rails. The registered staff, Director of Recreation and the DNC confirmed that the resident was not assessed for the use of bed rails. The DNC indicated that residents did not require to be assessed for the use of half rails.

Residents noted above lived in the same home area. A review of the home's "Bed Entrapment Audit" that was completed in September, 2014, indicated that there were a number of beds that failed the zones of entrapment in the same home area where these residents lived. The Director of Recreation and the Director of Nursing Care (DNC) indicated that, since the non-compliance was issued for bed entrapment during the RQI in 2014, the home had started the process of rectifying the beds that failed the zones of entrapment. They confirmed that the failed entrapment zones for the beds on the home area had not yet been corrected.

The home did not ensure that all residents were assessed for the use of bed rails, their bed systems were evaluated to minimize risk to residents and that steps were taken to prevent resident entrapment taking into consideration all potential zones of entrapment. [s. 15. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's Nursing policy, "Wound/Skin Care", Tab 04-78 last reviewed on January 9, 2015, directed staff to do the following regarding the assessment of alterations to skin integrity:

"On an ongoing basis, the PCA will complete the Skin Assessment, typically on each bath day, and record on the Resident's Flow sheets if no concerns need to be addressed. If there is a concern, it will be documented using the 'Twice Weekly Skin Assessment Form' and a 'Skin Assessment Concerns Form' will be completed and given to the Registered Team Member."

The policy noted above was not complied with, regarding the following residents who had areas of alteration in skin integrity:

A) Three quarterly skin assessments conducted in 2014 and 2015 for resident #100 indicated that they had two areas of altered skin integrity. Interview with registered staff confirmed that the resident continued to exhibit these areas of altered skin integrity. Review of the resident's health records indicated that, during a six week time period in 2015, Personal Care Aid (PCA) staff had recorded on resident flow sheets that skin assessments had been completed one time of a possible 14 entries, and had not documented using the 'Twice Weekly Skin Assessment Form' according to the home's policy.

B) Two quarterly skin assessments completed in 2015, for resident #105 indicated that they had two areas of alteration of skin integrity. Review of health records indicated that, over a one month time period, Personal Care Aid (PCA) staff had

recorded on resident flow sheets that skin assessments had been completed three times of a possible eight entries, and had not documented using the 'Twice Weekly Skin Assessment Form' according to the home's policy.

C) Three quarterly skin assessments completed in 2015 for resident #108, indicated that they had two areas of alteration of skin integrity. Review of the resident's health records indicated that, between over a six week time period, Personal Care Aid (PCA) staff had recorded on resident flow sheets that skin assessments had been completed six times of a possible 14 entries, and had not documented using the 'Twice Weekly Skin Assessment Form' according to the home's policy.

During interviews, registered and non registered staff who cared for residents #100, #105 and #108 confirmed that the flow sheets had not been consistently completed as noted, and the 'Twice Weekly Skin Assessment Form' had not been completed for these residents according to the home's policy. Interview with the DNC confirmed that the Skin and Wound policy had not been complied with. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Human Resources policy, "Prevention of Abuse in Long-Term Care", Tab 04-06 last revised November, 2013, directed any team member who had reasonable grounds to suspect abuse, to immediately report the incident to the team leader, charge nurse, immediate supervisor or any leadership team member. Upon receiving a report of suspected abuse the team leader was directed to immediately involve the charge nurse and/or neighbourhood coordinator, who were then directed to report immediately to the Ministry of Health and Long Term Care.

Review of the home's staff training regarding reporting certain matters to the Director revealed that it did not include that any staff person who had reasonable grounds to suspect that items noted in section s. 24(1) had occurred or may occur should immediately report the suspicion and the information upon which it was based to the Director. During interview on June 26, 2015, the home's AGM confirmed this.

Record review and staff interviews revealed that, on an identified day in 2015, a PSW heard resident #301 yelling from their room. The PSW entered the resident's room where they observed a second PSW, who was providing care to resident #301, using physical force to remove the resident's clothing which nearly resulted in the resident falling off of the toilet. The responding PSW verbally reported the incident to the team leader after the incident occurred and left a written statement outlining the incident in the neighbourhood coordinator's (NC) mailbox on the day after the incident occurred. The NC did not receive the statement until two days after the incident. The home's DNC submitted a critical incident report notifying the Ministry of Health and Long Term Care three days after the incident. Interview with the team leader revealed that incident was not immediately reported to the charge nurse or neighbourhood coordinator as per the home's policy and that the Ministry of Health and Long Term Care was not notified immediately. [s. 20. (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, without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.

During this inspection resident #106 was observed in bed with one three quarter rail applied while in bed. The written plan of care indicated that the resident used the bed rail for repositioning. The health records indicated that the resident was not assessed for the bed rail use as a PASD and that the alternatives had not been considered and tried to assist the resident with routine activity of living. The AGM confirmed that alternatives had not been considered for resident #106 and that the resident was not assessed to determine if the rail used as PASD had restraining properties.

The AGM also indicated that none of the residents in the home that used half rails or one rail while in bed were assessed to determine if the rails that were used as PASDs had restraining properties. Interview with the AGM and review of the homes policy "Restraint & PASD Procedure in LTC", last reviewed January 25, 2015, indicated that the home only applied the decision tree to determine if a physical device was used as a PASD had restraining properties when table trays, tilt wheelchairs, seat belts and full rails were in use.

The home failed to ensure that resident #106 was assessed for the use of bed rails as a PASD, whether alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living. [s. 33. (4) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living, 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Review of resident #100's health record indicated that, on a day in June, 2015, staff noted the resident had an area of altered skin integrity that could not be explained. An initial assessment of this skin area using a clinically appropriate assessment instrument could not be located in the resident's health record. During interview, the

Registered Practical Nurse (RPN) confirmed that the new area of altered skin integrity for resident #100 had not been assessed by a registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. The Director of Nursing Care (DNC) confirmed that the resident should have had an initial assessment with the new area of altered skin integrity. (526)

B) Review of resident #105's health record indicated that, on a day in May, 2015, the resident had a new area of altered skin integrity that required treatment. An initial assessment of this skin area using a clinically appropriate assessment instrument could not be located in the resident's health record. During interview, an RPN confirmed that the new area of altered skin integrity for resident #105 had not been assessed by a registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (526)

C) Review of resident #403's health record indicated that on a day in June, 2015, the resident had developed an area of altered skin integrity that required contact precautions and treatment. The resident's health record did not include an initial skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. Registered staff and the DNC confirmed this. [s. 50. (2) (b) (i)]

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

A) Resident #100's RAI MDS assessment completed over two quarters in 2014 and 2015, indicated that the resident had two areas of altered skin integrity. The Quarterly Skin Assessments completed over the same two quarters and one following them indicated that the resident had two areas of skin redness. Review of the resident's health record indicated that they had not been assessed weekly for these areas of skin alteration. The resident's plan of care completed at the time of the third skin assessment directed staff in the care of the resident's altered skin integrity. During interview, the RPN stated that there had been no weekly skin assessments completed for resident #100 regarding two areas of altered skin integrity when clinically indicated. (526)

B) Resident #105's RAI MDS assessment completed over two quarters in 2015

indicated that the resident had two areas of altered skin integrity. The Quarterly Skin Assessments completed during these two quarters, indicated that the resident had two areas of skin alteration, was receiving treatment, that the resident was frequently incontinent and sat in a wheelchair for extended periods of time. Review of the resident's health record indicated that they had not been reassessed weekly for these areas of skin alteration. The document the home referred to as resident #105's care plan directed staff to assess skin at every care opportunity for potential open areas and ulcers at least weekly. During interview, the RPN stated that there had been no weekly skin reassessments completed for resident #105 regarding two areas of altered skin integrity when clinically indicated. (526)

C) Resident #108's RAI MDS assessment completed over two quarters in 2015, indicated that the resident had two areas of altered skin integrity. The Quarterly Skin Assessments completed completed during these two quarters, indicated that the resident had two areas of skin alteration and was receiving treatment, was sitting most of the day, and was incontinent. Review of the resident's health record indicated that they had not been reassessed weekly for these areas of skin alteration. During interview, the RPN stated that there had been no weekly skin reassessments completed.

During interview, the RN and DNC confirmed that weekly skin assessments were not routinely completed unless there was an open area of the skin; therefore residents receiving treatment for Stage I wounds were not assessed weekly. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident monitoring and internal reporting protocols were developed to meet needs of residents with responsive behaviours.

A) Resident #401's RAI MDS assessment completed in 2015 indicated that the resident wandered and was resistive to care daily, and had physically abusive and socially inappropriate behaviours one to three days during the previous seven day observation period. Review of Behavioural Support Ontario (BSO) notes completed in 2014, indicated that resident #401 wandered and would become responsive when redirected. Interviews with direct care staff confirmed this snf stated that the resident

would wander into co residents' rooms, causing both residents to become agitated which contributed to altercations between resident #401 and co residents including verbal and physical aggression.

Review of progress notes indicated that, since admission to the home in 2014, resident #401 had altercations with co residents when entering their rooms on at least seven occasions in 2014, and on six occasions in 2015.

B) Resident #402's RAI MDS assessment completed in 2015 indicated that they wandered daily during the previous seven day observation period. Review of BSO notes dated four months earlier indicated several different interventions and that staff should redirect potential wanderers away from resident #402's room as this could become upsetting. Interviews with direct care staff confirmed this and staff stated resident #402 was not usually responsive toward co residents.

Review of progress notes for resident #401 and #402 indicated that, on a day in 2015, resident #401 wandered into resident #402's room causing resident #402 to become upset and yell at resident #401 to get out of their room. Resident #401 was observed by staff to be physically assaulting resident #402.

During interview, direct care staff stated that they would try to monitor wandering residents' whereabouts in the neighbourhood, but did not have a protocol in place that directed them to monitor residents at regular intervals or to report or document monitoring of residents' wandering and locations.

During this inspection the LTC inspector asked staff where resident #401 was and they stated that the resident was wandering and didn't know where they were. The resident was found by the LTC inspector in an empty room belonging to a resident with whom resident #401 had an altercation several days ago. Registered staff verified that that resident #401's wandering was not monitored consistently, documented or reported to meet the needs of residents #401 and #402 with responsive behaviours.

During interview, the DNC verified that the home did not have a policy or protocol directing staff in the monitoring of residents who wandered to prevent or minimize altercations with co residents. [s. 53. (1) 3.]

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 following are developed to meet the needs of residents with responsive behaviours: 3. Resident monitoring and internal reporting protocols, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home’s dining and snack service included course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident’s assessed needs.

During a lunch meal observation on June 15, 2015 residents #302 and #303 were observed to be served the main course while they were consuming their course of soup. Interviews with the PSW assisting resident #303 and a family member who was assisting #302 revealed that residents had not requested to be served their main courses prior to the completion of their soups. Review of the care plans for the residents revealed that exceptions to course by course meal service were not indicated as assessed needs of the residents.

The home's policy "Serving of Food" last revised November 2013, indicated that “meals will be served one course at a time, unless residents request otherwise”. The home's policy for "Meal Time Responsibilities" last revised November 2013, indicated “residents will be offered their meal course by course unless otherwise indicated by the resident or by the resident’s assessed needs”. The Food Services Manager (FSM) confirmed that it was the expectation of the home that the meal was served course by course. [s. 73. (1) 8.]

2. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On June 26, 2015 the Long Term Care Homes (LTC) Inspector observed resident #204 to be served the main course at lunch meal service and then the course of dessert with no staff available to provide assistance to the resident. It was not until the LTC Inspector questioned the level of assistance for this resident that a staff member sat beside the resident and assisted them with the dessert.

A review of the resident’s plan of care revealed that the resident was assessed to be a high nutritional risk with weight below the goal weight range and required total feeding assistance at meals. The home's policy "Table Service" last revised November 2013, indicated that “No resident who requires assistance with eating or drinking is served a meal until someone is available to provide assistance”. Interview with registered staff confirmed that the resident required total feeding assistance at meals. [s. 73. (2) (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 home has a dining and snack service that includes, at a minimum, the following elements: Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs; and that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

During the initial tour of the home on June 15, 2015 the LTC Inspector noted that the floors in the spa rooms containing the shower, on the Brant and Appleby neighbourhoods, had a black coloured build-up on the grout. This was seen again during observations on June 25, 2015. An interview with the home's Director of Environmental Services (DES) revealed that the home had transitioned from using an external contractor to clean the grout in the spas to completing the cleaning internally; however, no schedules had been developed for completing this cleaning. The DES confirmed that the grout contained black build-up in the identified neighbourhood spa rooms and were not adequately cleaned. [s. 87. (2) (a) (ii)]

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 procedures are developed and implemented for cleaning of the home including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

Review of the home's investigation notes for a complaint made to the home revealed that on a day in 2015, resident #400's family member asked staff for assistance in cleaning up what looked like another resident's urine on the floor and couch in resident #400's room. A staff member was noted to confirm that it was urine stating that they would clean it up.

According to LTC Inspector's interview with resident #400's family member, staff confirmed that the liquid was likely urine and was also soaked into the cushions of a couch located in the resident's room. The family member stated that they observed the urine at 1700 hours and it was still there at 1900 hours.

During interview with the LTC Insepctor and while referring to the home's investigative notes, the neighbourhood coordinator confirmed that the staff person had forgotten to clean up the spill as they had become distracted by care needs of other residents. The Assistant General Manager (AGM) confirmed during interview that the urine spill should have been cleaned up as soon as it was observed by staff, and that staff had not implemented the home's infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A) During the initial tour of the home on June 15, 2015 the LTC Inspector noted that the oven in the Appleby home area's Country Kitchen was functional and was not being monitored by staff. An interview with a Registered Nurse (RN) confirmed that the oven was functional. The RN further revealed that, for residents' safety, it was the home's practice to turn off the breaker to the oven when the oven was not in use. The RN immediately had the breaker turned to the off position rendering the oven non-functional.

B) During the initial tour of the home on June 15, 2015, the LTC Inspector noted that the spa on the Brant neighbourhood had damage to the tiles on the wall between the toilet and the shower. On June 25, 2015, the damaged tiles remained exposed and were noted to have sharp edges. An interview with the home's Director of Environmental Services confirmed that the broken tiles could pose a safety risk to residents using the spa room. [s. 5.]

WN #13: The Licensee has failed to comply with LTCHA, 2007, 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

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home in a conspicuous and easily accessible location.

On June 24, 2015, the LTC Inspector was unable to locate the home's policy to promote zero tolerance of abuse and neglect of residents posted in the home. The home's Director of Nursing Care (DNC) confirmed that the policy was not posted in home. [s. 79. (3) (c)]

2. The licensee failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were posted in the home in a conspicuous and easily accessible location.

During the initial tour of the home on June 15, 2015 the Long-Term Care Homes LTC Inspector noted the following:
i) The report for inspection number 2014_188168_0028, report date December 5, 2014, included only seven pages of the licensee copy of the 20 page report;
ii) The report for inspection number 2013_191107_0012, report date October 4, 2013, was not posted in the home.

An interview with the home's AGM confirmed that the reports were not posted in the home. [s. 79. (3) (k)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in the development and carrying out of the satisfaction survey.

Interview with the chair of the home's Family Council and review of the Family Council minutes revealed that the advice of the Family Council had not been sought in the development and carrying out of the satisfaction survey. Interview with the home's AGM confirmed that the advice of the Family Council was not sought in the development and carrying out of the satisfaction survey. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review and staff interviews revealed that on an identified day in 2015, a PSW heard Resident #301 yelling from their room. The PSW entered the resident's room where they observed a second PSW, who was providing care to resident #301, using physical force to remove the resident's clothing which nearly resulted in the resident falling off of the toilet. The responding PSW verbally reported the incident to the team leader after the incident occurred and left a written statement outlining the incident in the neighbourhood coordinator's (NC) mailbox the following day. The NC did not receive the statement until two days following the incident. An interview with the home's Director of Nursing Care (DNC) and review of the of the critical incident report confirmed that the substitute decision maker for resident #301 was not notified about the incident until two days after the incident had occurred. [s. 97. (1) (b)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in a medication cart that was secured and locked.

On June 19, 2015 at 1152 hours, the LTC Inspector observed a medication cart that was left unattended and unlocked in the hallway of a resident neighbourhood in front of the lounge area for approximately 5 minutes. The registered staff indicated that it was an expectation to lock the medication cart when unattended but they were in a hurry to go attend to a resident and forgot to lock it. The licensee failed to ensure that the medication was secure and locked when unattended. [s. 129. (1) (a)]

Issued on this 21 day of August 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : THERESA MCMILLAN (526) - (A1)

Inspection No. / No de l'inspection : 2015_265526_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-002692-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 21, 2015;(A1)

Licensee / Titulaire de permis : OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

LTC Home / Foyer de SLD : THE VILLAGE OF TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JO-ANNA GURD

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall do the following:

1. Include all individualized planned care in each residents' written plan of care particularly in the area of management of responsive behaviours so that staff have clear directions to provide care to residents.

2. Educate all relevant staff in maintaining updated written plans of care so that residents' individual care needs are accurately reflected and provide clear directions to direct care staff for individualized resident care.

3. Provide direct care staff with ready and immediate access to the complete written plan of care (ie. the 'care plan').

Grounds / Motifs :

1. This area of non compliance was previously issued as a VPC on December 5,

2014.

2. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A review of clinical documentation revealed that resident #300 had physically responsive behaviours which were triggered by co-residents entering their room and that these behaviours placed co-residents at risk of harm. Documentation further revealed that the resident was involved in four altercations with co-residents who had wandered into their room during a three month time period in 2014.

Review of clinical documentation three months before this time period, indicated that a wander guard was to be placed on the resident's door to prevent co-residents from accessing resident #300's room. Behavioural Supports Ontario (BSO) notes during the three month period noted above, indicated the wander guard remained an appropriate intervention to avoid altercations. A review of the resident's written plan of care during the time period did not include the wander guard, or any other diversional interventions, to prevent co-residents from entering resident #300's room.

An interview with the home's Assistant General Manager (AGM) revealed that it was the home's expectation that interventions related to responsive behaviours, including wander guards, would be included in the written plan of care for the resident. (503)

B) Progress notes from a day in 2015, described an altercation between resident #401 and #402 that was precipitated by resident #401 wandering into resident #402's room. Resident #402 was found by staff yelling at resident #401 to get out and resident #401 struck resident #402.

Review of resident #402's clinical assessment by Behavioural Support Ontario (BSO) indicated that the resident liked their privacy, did not like residents wandering into their room, and could exhibit responsive behaviours toward co-residents particularly if co-residents wandered into their room. BSO recommended that staff include in resident #402's plan of care that co-residents be directed away from each other to decrease the risk of conflict, the use of a wander guard and 'stop' signage or mat in front of door to deter wanderers. Review of the document the home referred to as resident #402's care plan revealed that recommendations made by BSO were not included in the written plan of care.

During this inspection, a wander guard was observed to be in place in front of resident #402's doorway, however there was no "stop" sign or mat observed. In addition, during this inspection, the LTC inspector asked staff where resident #401 was located. Staff stated that the resident was wandering and they didn't know where the resident was. Resident #401 was found by the LTC inspector in an empty room belonging to a resident with whom resident #401 had an altercation several days earlier. Registered staff verified that resident #401's wandering was not monitored consistently and staff were not always aware if resident #401 attempted to enter resident #402's room.

Interviews with direct care staff confirmed that resident #402 did not like co-residents entering their room, that resident #401 frequently wandered into co-resident's rooms and that this could lead to responsive behaviours and altercations. Registered staff reviewed resident #402's written plan of care and confirmed that it did not set out the resident's planned care according to BSO recommendations to prevent altercations between resident #402 and co-residents. (526)

C) Review of resident #403's health record and interview with registered staff confirmed that the resident had developed an alteration in skin integrity that required contact precautions and treatment in June 2015. A sign was posted on the resident's door alerting staff to the need for contact precautions and a cupboard designed to hold personal protective equipment was positioned outside of the resident's room throughout this inspection; the container was observed to be empty on June 26, 2015.

During interview, a Personal Care Aid (PCA) stated an incorrect reason for contact precautions. Inspection of the resident's written plan of care revealed no entries informing staff of the planned care for resident #403 specific to their altered skin integrity or contact precautions. The Director of Nursing Care (DNC) confirmed that the written plan of care did not set out the planned care for resident #403. [s. 6. (1) (a)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Oct 31, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall do the following

1. Protect residents from abuse by anyone including by visitors to the home and staff members.

2. Educate staff according to legislative requirements regarding their obligations to residents in the following areas:
i) the prevention of abuse and neglect;
ii) what to do and how to respond to protect residents when abuse or neglect is seen or suspected;
iii) reporting matters to the Director (Ministry of Health and Long Term Care).

3. Evaluate each incident of abuse and neglect quarterly and annually, document this evaluation, make recommendations as needed, implement the recommendations and evaluate the effectiveness of the home s strategies to prevent abuse and neglect at least quarterly and annually.

Grounds / Motifs :

1. This Non Compliance was previously issued as a VPC on December 5, 2014.

2. The licensee failed to protect residents from abuse by anyone.

A) Record review and staff interviews revealed that on an identified day in 2015, a personal support worker (PSW) heard resident #301 yelling from their room. The PSW entered the resident's room where they observed a second PSW, who was providing care to resident #301, using physical force to remove the resident's clothing which nearly resulted in the resident falling off of the toilet. The responding PSW asked if the PSW providing care required assistance, and when this was declined, left the resident's room to attend to other residents. The PSW who witnessed the incident reported the observations to the Team Leader and later checked on the resident who appeared upset.

The home's subsequent investigation found that the resident had not suffered any ill effects. The home's Human Resources policy, "Prevention of Abuse in Long-Term Care", Tab 04-06 dated November 2013, directed the Team Leader to immediately separate the resident from the alleged offender if the abuse was witnessed. Interviews with the responding PSW and the Team Leader confirmed that despite the abuse being witnessed, the PSW who was providing care to the resident, was not removed from caring for the resident or other residents in the home. Following the home's investigation the PSW who was witnessed to be using physical force was terminated.

B) A review of clinical documentation, investigative notes, critical incident report and interviews with staff revealed that on a day in 2014, an identified Registered Practical Nurse (RPN) heard yelling from the room of resident #300, and upon responding, found a visitor in the home physically assaulting resident #401. The RPN convinced the visitor to stop what they were doing and assessed the resident. There were no reported ill effects to the resident.

Interviews with registered staff and the home area's neighbourhood coordinator revealed that the visitor had complained about resident #401 and other residents entering the room of resident #300 on previous occasions. A review of the progress notes for resident #300 revealed that the same visitor was involved in a physical altercation with resident #401 several months earlier. This was verified during interview with the registered staff who wrote the progress note about the incident.

An interview with the home's Assistant General Manager (AGM) revealed that the first incident was not documented in an internal incident report and that they were unaware that this incident had occurred; the AGM further revealed a critical incident report informing the MOHLTC Director about the first incident was not submitted. The licensee failed to protect resident #401 from abuse by a visitor to the home. Steps had not been taken following a previous known incident of abuse upon resident #401, by the visitor of resident #300 and this was followed by further abuse that occurred six months later. [s. 19. (1)] (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Sep 18, 2015(A1)

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1. Re-assess all bed systems to determine if they pass zones of entrapment 1-4. Refer to Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

2. Where bed systems have failed zones of entrapment 1-4, the home shall immediately mitigate any entrapment risks to residents.

3. Develop a comprehensive bed safety assessment tool using, as a guide, the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".

4. An interdisciplinary assessment of all residents using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.

5. The home shall continue to re-assess the bed system and complete the comprehensive bed safety assessment when there is a change in resident's condition, when a new resident is admitted to the home and when any parts of the bed systems are changed.

6. Update all resident care plans to include whether bed rails are used, how many, which side of the bed and the reason. Include the use of any interventions, such as bed accessories if the bed has not passed all entrapment zones.

7. Educate all staff that provide direct care to residents on bed safety, bed rail use and entrapment zones.

Grounds / Motifs :

1. This Non Compliance was previously issued as a VPC on December 5, 2014.

2. The licensee failed to ensure that where bed rails were used,
a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices to minimize risk to residents;
b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
c) other safety issues related to the use of bed rails were addressed, including height and latch reliability.

A) Resident #104 was observed in bed with one three quarter rail and one half rail in the up position. Review of health records indicated that there was no assessment completed for the use of bed rails. The "Bed Entrapment Audit" sheet dated September 25, 2014, indicated that the bed failed the zones of entrapment in zones 2 and 4.

B) Resident #106 was observed during this inspection to have one three quarter rail applied while resident was in bed. The health records were reviewed and indicated that the resident was not assessed for the use of the bed rail. The registered staff and the DNC confirmed that the resident was not assessed for the use of the bed rail. The bed entrapment audit that was completed in September 2014, indicated that this resident's bed failed the zones of entrapment in zones 2 and 4. The three quarter rail on resident's bed was noted to be wiggling.

C) During this inspection, the Long Term Care Homes (LTC) Inspector observed the Director of Recreation removing resident #200's three quarter bed rail from their bed system. Resident #200 had two three quarter bed rails on the bed. The Director of Recreation indicated that the resident did not require two full rails (the home identified them as full rails). The Director of Recreation indicated that upon resident's admission in 2015, the home did not remove two full rails from their bed and that the resident only required one full rail and one half rail on the opposite side while in bed. The health records were reviewed and indicated that the resident was not assessed for the use of bed rails. The registered staff, Director of Recreation and the DNC confirmed that the resident was not assessed for the use of bed rails. The DNC indicated that residents did not require to be assessed for the use of half rails.

Residents noted above lived in the same home area. A review of the home's "Bed Entrapment Audit" that was completed in September, 2014, indicated that there were a number of beds that failed the zones of entrapment in the same home area where these residents lived. The Director of Recreation and the Director of Nursing Care

(DNC) indicated that, since the non-compliance was issued for bed entrapment during the RQI in 2014, the home had started the process of rectifying the beds that failed the zones of entrapment. They confirmed that the failed entrapment zones for the beds on the home area had not yet been corrected.

The home did not ensure that all residents were assessed for the use of bed rails, their bed systems were evaluated to minimize risk to residents and that steps were taken to prevent resident entrapment taking into consideration all potential zones of entrapment. [s. 15. (1)] (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Oct 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21 day of August 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : THERESA MCMILLAN - (A1)

Service Area Office /
Bureau régional de services : Hamilton