Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2015	2015_265526_0006	H-002112-15	Resident Quality Inspection

Licensee/Titulaire de permis

HALTON HEALTHCARE LTC INC.
327 REYNOLDS STREET OAKVILLE ON L6J 3L7

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

WYNDHAM MANOR LONG TERM CARE CENTRE
291 REYNOLDS STREET OAKVILLE ON L6J 3L5

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

THERESA MCMILLAN (526), ASHA SEHGAL (159), LALEH NEWELL (147), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, and 24, 2015.

The following complaint and critical incident inspections were conducted simultaneously to this inspection: H-000668-14, H0001204-14, H-001275-14, H-002096-14, H-001446-14, and H-000922-14. Follow up inspection H-001190-14 was also conducted during this RQI inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Maintenance Supervisor, Registered Dietitian (RD), Dietary Manager, Maintenance Manager, Program Manager, Office Manager, registered staff, housekeeping staff, environmental staff, dietary staff, Physiotherapist (PT), physiotherapy assistant (PTA), Behaviour Supports Ontario (BSO) staff, Personal Support Workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed staff and residents, reviewed resident health records, meeting minutes, policies and procedures, schedules, education records, dietary records, and housekeeping and maintenance records.

The following Inspection Protocols were used during this inspection:

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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

14 WN(s)
6 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_214146_0017	526

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 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, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) The document the home referred to as resident #300's "care plan" completed during a month in 2015, indicated that the resident used two one half bed rails to assist with turning and positioning. Non registered staff confirmed during interview that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that the resident had not been assessed for the use of bed rails in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. The DOC confirmed this.

B) The document the home referred to as resident #304's "care plan" completed during a month in 2015, indicated that the resident could hold the bed rail and roll to the side of their bed. Non registered staff confirmed during interview that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that the resident had not been assessed for the use of bed rails in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. The DOC confirmed this.

The DOC stated that, unless bed rails were determined to be a restraint, residents had not been assessed in their bed systems to minimize the risks associated with bed rails for each resident. [s. 15. (1) (a)]

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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident-staff communication and response system could be easily accessed and used by residents at all times. [17(1)(a)]

A) Observation of resident rooms #1214 and #1208 on March 13, 2015, revealed that the residents’ bathroom station "call bells" were broken and not accessible to the residents from the toilet. When call bells in these bathrooms were pulled, the green handle/rope of the call bell became separated from the cord attached to the plate on the wall that activated the call bell. The ADOC was informed, who then tested these call bells and confirmed the call bell cord was pulled away from the cord attached to the plate on the wall, and not accessible to the residents.

B) On March 9, 2015, during the tour of the home the call bell cord was missing in the spa room in Palermo House. The Maintenance Supervisor confirmed this call bell cord was missing, that the call bell was not functioning, and could not be accessed easily. The Maintenance Supervisor also confirmed that they had been aware of this issue for four months prior to the time of this inspection.

C) Interview with the Maintenance Supervisor on March 16 and 17, 2015, confirmed the following the issues with call bells as identified by the inspector on March 13, 2015: the bathroom station call bells tested in rooms #1216, #1247, #1249, #1255, #1308, #1325, #2517 and #2553, were found to be non-functioning with the call bell cord missing and separated from the cords attached to main junction that activated the call bell, and therefore not easily accessible to the residents. The Maintenance Supervisor further confirmed the parts for the broken call bells were ordered on March 13, 2015. [s. 17. (1) (a)]

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 is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff complied with the written policy to minimize the restraining of residents, in relation to the following: [s.29 (1) (b)]

Staff did not comply with home's policy “Personal Assistance Service Devices” Reference # RESI-10-01-06 dated November 2012. The protocol directed staff to do the following: “The assessment for the use of a [personal assistive services device] PASD must be completed by the interdisciplinary team prior to the implementation of the PASD. A PASD shall be used only after all other alternative means of assisting the resident with an activity of daily living have been trialed, evaluated and the resident outcomes documented. The need for PASD must be reassessed on a minimum of a quarterly".

Staff did not comply with the direction when clinical documentation confirmed there were not quarterly assessments of PASD being used for resident #039. Interview with the DOC confirmed that the last assessment of PASD being used for the resident was completed more than two years prior to this inspection. The policy directed that alternative to PASD to be tried, evaluated and outcomes documented. Staff did not comply with this direction when staff interviews and clinical records confirmed that alternatives to PASD for resident #039 were not tried. [s. 29. (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 there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and (b) shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids were prepared, stored and served using methods that preserved taste, nutritive values, appearance and food quality. [O.Reg.79/10, s.72 (3) (a).

On March 9, 2015, food items served to residents at the noon meal were not prepared to preserve the appearance, taste and quality. The meal served to residents receiving minced and pureed food did not appear to be appetizing and nutritious. The consistency of the minced peas and green salad was more of puree texture. The food items were glue-like and glossy in appearance. The pureed food items were noted to be running into each other on the plate and did not hold their form. Pureed foods that were too runny could be difficult for residents to swallow.

In addition, the nutritional value and the flavour of the pureed and minced food items were compromised due to excess use of thickener and liquid. [s. 72. (3) (a)]

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 food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

The home's "Resident Care Quality Indicators" policy for "Physical Restraints" reference number RESI-10-01-01 last reviewed November 2012 included but was not limited to directing staff to ensure that the restraint was appropriately applied. The policy included the manufacturer's "Pelvic Support User's Guide" and the vendor's "Belt Application for Proper Positioning" which directed staff to apply the lap belt "not too loose to allow client to slide under belt…just enough space for two fingers to fit between the belt and pelvic crest". The DOC confirmed that this was the home's expectation.

A) Resident #038 had a diagnosis that limited their movement and required total assistance. On March 10, 2015, resident #038 was observed sitting in a tilt wheelchair with a lap belt applied approximately eight inches from the resident's torso. The resident was observed to be unable to release the belt. Personal support worker (PSW) staff interviewed indicated that the lap belt was loose and proceeded to tighten it to two finger

widths from the resident’s torso. The DOC confirmed that resident #038’s lap belt had not been applied according to manufacturer’s instructions.

B) Resident #304 had a diagnosis that limited their movement requiring extensive assistance. On March 13, 2015, resident #304 was observed sitting in a wheelchair with a lap belt applied six inches from their torso. The resident was observed to be unable to release the belt. The Long Term Care Homes (LTC) Inspector alerted a registered practical nurse (RPN) who confirmed that the lap belt was loose and proceeded to tighten it to two finger widths from the resident’s torso. The DOC confirmed that resident #304’s lap belt had not been applied according to manufacturer’s instructions.

C) On March 13, 2015 resident #012 was observed sitting in their wheelchair with their lap belt applied eight inches from their torso. The LTC Inspector alerted an RPN who confirmed that the lap belt was loose but stated not being aware of the manufacturer’s instructions. After learning about the proper application for lap belts, the RPN proceeded to tighten it so that it was positioned two finger widths from the resident’s torso. The DOC confirmed that resident #304’s lap belt as a PASD should have been applied according to manufacturer’s instructions.

D) Resident #035’s plan of care indicated the resident was a high risk for falling and directed the staff to apply the seatbelt at all times when the resident was sitting in the wheelchair for safety. On March 10, 2015, the resident was observed to have a front fastening seat belt that was noted to be loose fitting, approximately the distance of four fingers width between the belt and the resident’s abdomen. A PSW who provided care to the resident tightened the seat belt after being asked by the LTC Inspector about the appropriate application of the belt. Registered staff confirmed that the use of the device was a restraint and that it was not applied according to manufactures’ instruction, so that it was secured snugly around the resident, approximately the distance of two finger widths between the resident and the abdomen. (159) [s. 110. (1) 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 following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer’s instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer’s instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer’s instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD used under section 33 of the Act was applied by staff in accordance with the manufacturer's instructions.

The home's "Resident Care Quality Indicators" policy for "Physical Restraints" reference number RESI-10-01-01 last reviewed November 2012 included but was not limited to directing staff to ensure that the restraint was appropriately applied. The policy included the manufacturer's "Pelvic Support User's Guide" and the vendor's "Belt Application for Proper Positioning" which directed staff to apply the lap belt "not too loose to allow client to slide under belt…just enough space for two fingers to fit between the belt and pelvic crest". The DOC confirmed that this was the home's expectation.

A) On March 9, 2015, resident #011 was observed sitting in their wheelchair with a lap belt applied six inches from their torso. The resident told the LTC Inspector that they could undo the belt but felt more secure with the lap belt applied. During interview, the restorative care staff person stated that the lap belt was applied for the resident's comfort and adjusted it five minutes after learning about the safe application according to the manufacturer's instructions.

Again, on March 13, 2015, the resident's lap belt was observed to be applied six inches from the resident's torso. A PSW confirmed that the lap belt was loose and tightened it to two finger widths. The DOC confirmed that resident #011's lap belt should have been applied according to manufacturer's instructions.

B) The document the home referred to as resident #300's "care plan" last updated in March, 2015, indicated that the resident had a lap belt as a PASD. On March 10, 2015, resident #300 was observed sitting in their wheelchair with a lap belt applied six inches from their torso. A Registered Practical Nurse (RPN) was alerted and removed the lap belt stating that it wasn't needed, and walked away. The Assistant Director of Care (ADOC) intervened and confirmed that the lap belt was loose and proceeded to tighten it. The ADOC confirmed that resident #300's lap belt as a PASD should have been applied according to manufacturer's instructions. [s. 111. (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 ensure that a PASD used under section 33 of the Act, (b) is applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Between March 9 and 13, 2015 the LTC Inspector noted resident #005 having a urine odour. The resident's Resident Assessment Instrument Minimum Data Set (RAI MDS) completed during a month in 2015, and continence assessment completed in the same month indicated that the resident was continent of bowel and bladder. During interview, PSW staff stated that the resident: was continent with rare bladder incontinence; used a

pull up brief independently; was mostly independent with toileting however needed assistance with pericare; had an occasional urine odour; and would deny incontinence or assistance from staff. However, the most recent document the home referred to as the "care plan" and "Kardex" completed three months prior to the assessment and that was available to direct care staff indicated the following about resident #005's continence:

- Can be frequently incontinent of bowel, requires more assistance with hygiene. Need assistance to use toilet;
- Currently continent of bladder and independent with toilet use;
- Currently usually continent with assistance with toilet use;
- Requires extensive assistance of one staff for toileting. Knows where and how to go to BR on their own but needs reminders and assistance to change product and pericare;
- Reminders and assistance: 0800 1100 1400 1600 2000 and prn during the night.

During interview, RPN and DOC confirmed that direct care staff did not have clear direction regarding the resident's continence management in terms of level of continence, required assistance, preferences regarding continence management, if a brief was used and the type of brief used by resident #005. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Review of resident #012's health record revealed that the resident was provided treatment for an alteration in skin integrity during a 14 day time period in 2014; the treatment was discontinued when the issue resolved. The document the home referred to as resident #012's "care plan" completed three months later directed staff to apply the treatment that had been discontinued.

Interview with registered staff confirmed that the resident was no longer receiving the treatment and that the "care plan" should not include the application of the treatment. During interview, the RAI Coordinator and ADOC confirmed that the resident's plan of care had not been reviewed and revised when the care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure resident #100 was protected from abuse and neglect by the staff in the home.

During review of resident #100's clinical record, it was noted the resident had a fall during the night shift during a month in 2014. On March 18, 2015, the home's fall incident investigation report was reviewed. This report combined with interviews with DOC, ADOC and PSW involved in the incident confirmed that a PSW care provider observed the resident sitting on the side of the hallway and was trying to get up from the floor; the PWS continued to pass by the resident and did not attend to resident.

On March 19, 2015, interview with the PSW involved validated the information and confirmed that they had made a mistake by not attending to the resident immediately. The Director of Care (DOC) reported to the Long Term Care (LTC) inspector that the incident did not require a transfer of the resident to hospital and the resident was seen by the Nurse Practitioner in the home.

Interviews with the DOC and ADOC confirmed the staff member involved in the incident was disciplined regarding the neglect and safety of resident #100. [s. 19. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident 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. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that restraint by a physical device was included in the resident's plan of care.

A) On March 10, 2015, resident #038 was observed sitting in a tilt wheelchair with a lap belt in place. The resident was observed to be unable to release the belt. Review of the resident's health record indicated that the application of a lap belt as a restraining device was not included in the plan of care. During interview, personal support worker staff (PSW) confirmed this. The PSW interviewed stated that they were not aware that the lap belt had been discontinued approximately two months earlier. The DOC confirmed that the lap belt as a restraining device was not included in resident #038's plan of care.

B) On March 13, 2015, resident #304 was observed sitting in a wheelchair with a lap belt in place. The resident was observed to be unable to release the belt. Review of the resident's health record indicated that the application of a lap belt as a restraining device was not included in the plan of care. During interview, an RPN and the DOC confirmed that resident #304 should not have had the lap belt in place as it was not included in their plan of care. [s. 31. (1)]

2. The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following were satisfied:

1. There was a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained;

2. Alternatives to restraining the resident had been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk referred to in paragraph 1;

3. The method of restraining was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1;

4. A physician, registered nurse in the extended class or other person provided for in the regulations had ordered or approved the restraining; and

5. The restraining of the resident had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Between March 9 and 13, 2015, resident #300 was observed sitting in a tilt chair. Review of the resident's health record indicated that the resident used a tilt chair for safety, that their lower extremities were weak, they had a poor gait for transfer, the resident would forget and attempt to get out of their chair without assistance and that the chair was used for the resident's safety.

Interview with registered and non registered staff confirmed that the tilt chair was used for resident #300 to prevent them from rising and that it acted as a restraint. Review of the resident's health record indicated that the tilt chair as a restraint had not been ordered by a physician or other person provided for in the regulations, and that the

restraint had not been consented to, by the resident or their substitute decision maker. [s. 31. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 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 were satisfied:

1. 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;

2. The use of the PASD was reasonable, in light of the resident’s physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living;

3. The use of the PASD had 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; and

4. The use of the PASD had 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.

A) On March 13, 2015 resident #039 was noted in the T.V. lounge to be sitting in a wheel chair that was tilted back. The position of the wheelchair inhibited the resident’s freedom of movement and the resident was not able to reposition the tilt chair. The plan of care indicated that the tilt wheelchair was be used as a PASD for positioning and comfort. The Registered staff confirmed that at time of this inspection there was no documentation in the clinical record that the use of the tilt wheelchair as a PASD had been assessed or alternative to the use of this device had been considered before including the use of this PASD in the resident’s plan of care. The DOC was unable to provide documentation to confirm that alternatives to the use of the devices were considered prior to the use of tilt wheelchair as a PASD.

B) On March 10, 2015, resident #300 was observed sitting in a wheelchair with a lap belt in place. The most recent document the home referred to as the “care plan”, indicated that the resident had a lap belt applied as a PASD and that the resident was able to fasten and unfasten it. Review of the resident’s health record indicated the resident had not been assessed for the lap belt as a PASD in terms of alternatives and the appropriateness of the PASD in light of their condition. The DOC confirmed this.

C) Between March 9 and 13, 2015, resident #304 was observed sitting in a tilted wheelchair. The most recent physician’s order that the tilt wheelchair was to be applied for comfort was dated two years earlier. The document the home referred to as the “care plan” completed two months prior to this inspection indicated that the resident was a high

risk for falls and also directed staff to tilt the resident's wheelchair when needed for comfort and positioning; registered staff confirmed this and stated that the resident was not able to ambulate while in the tilt chair.

However, review of the resident's health record confirmed that the resident had not been assessed for alternatives to the tilt chair or for the appropriateness of the tilt chair according to their condition or personal history. The DOC confirmed that the resident should have been assessed for the use of the tilt chair as a PASD.

D) Between March 9 and 13, 2015, resident #012 was observed sitting in a tilted wheelchair. A physician's order last revised 17 months previously, indicated that the tilt wheelchair was to be applied for comfort. The most recent document the home referred to as the "care plan" directed staff to tilt the resident's wheelchair when needed for comfort and positioning; registered staff confirmed this.

However, review of the resident's health record confirmed that the resident had not been assessed for alternatives to the tilt chair or for the appropriateness of the tilt chair according to their condition or personal history. The DOC confirmed that the resident should have been assessed for the use of the tilt chair as a PASD.

E) The following residents were found to have bed rails in place as PASDs between March 9 and 20, 2015:

i) The document the home referred to as resident #300's "care plan" completed during a month in 2015, indicated that the resident used a one half bed rail on each side to assist with turning and positioning. Non registered staff confirmed during interview on March 16, 2015, that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that they had not been assessed for the alternatives to the bed rails or their appropriateness as a PASD given their condition and previous history. In addition, approval by a person provided for in the regulations and consent for the use of bed rails had not been provided by the resident or their delegated decision maker. The DOC confirmed this.

ii) The document the home referred to as Resident #304's "care plan" completed during a month in 2015, indicated that the resident could hold the bed rail and roll to the side of their bed. Non registered staff confirmed during interview on March 16, 2015, that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that they had not been assessed for the alternatives to the bed rails or

their appropriateness as a PASD given the resident's condition and previous history. In addition, approval by a person provided for in the regulations and consent for the use of bed rails had not been provided by the resident or their delegated decision maker. The DOC confirmed this.

iii) The document the home referred to as Resident #012's "care plan" completed during a month in 2015, indicated that they would use bed rails to assist with turning. Non registered staff confirmed during interview on March 13, 2015, that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that consent for the use of bed rails as a PASD had not been provided by the resident or their delegated decision maker. The DOC confirmed this.

iv) The document the home referred to as Resident #038's "care plan" completed during a month in 2015, indicated that they would use a one half bed rail for mobility. Non registered staff confirmed during interview on March 16, 2015, that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that approval by a person provided for in the regulations and consent for the use of bed rails had not been provided by the resident or their delegated decision maker. The DOC confirmed this.

v) The document the home referred to as Resident #011's "care plan" completed during a month in 2015, indicated that they would use one half bed rails for mobility. Non registered staff confirmed during interview on March 16, 2015, that the resident used the bed rails to assist with bed mobility. Review of the resident's health record indicated that approval by a person provided for in the regulations and consent for the use of bed rails had not been provided by the resident or their delegated decision maker. The DOC confirmed this. [s. 33. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and position techniques when assisting a resident.

Resident #302’s RAI MDS assessment completed during a month in 2014, indicated that the resident had total dependence on staff for bed mobility, locomotion on and off the unit and for activities of daily living; extensive assistance was required for transferring between surfaces. During interview, PSW staff stated that resident #302 could not adjust their extremities independently and were totally dependent on staff for repositioning.

One month after the RAI MDS assessment, resident #302 was noted by a family member and staff to be improperly positioned while sitting in their wheel chair. According to family and staff observations recorded in the home’s investigative notes, the resident’s extremity was poorly positioned and appeared to cause distress. Interview with RPN staff during the home's investigation confirmed that the resident had not been positioned properly.

PSW’s interviewed by LTC Inspector confirmed that changes in the resident's positioning could cause discomfort. They stated that the plan of care had been updated so that staff monitor the resident's position in the wheelchair to ensure resident safety at all times. [s. 36.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident who demonstrated responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented.

Resident #012’s most recent RAI MDS completed during a month in 2015 indicated that the resident exhibited four types of behavioural symptoms one to three days during the previous seven day observation period. This most recent RAI MDS assessment and one completed three months previously, noted that the resident’s behaviour status deteriorated since the previous RAI MDS assessments. Review of flow sheets completed by non registered staff and interviews with PSW and RPN staff confirmed that the resident exhibited at least four types of responsive behaviours since three months previous to the most recent assessment. Interview with the Charge Nurse indicated that resident #012’s behavioural symptoms continued to develop and deteriorate since the resident’s admission in 2010. Review of the resident’s health record indicated that no documentation of the resident’s responsive behaviours were found in the progress notes or in other areas of the resident’s health record for behaviours that occurred three months prior to the most recent assessment to the time of this inspection.

The home’s “Resident Care” policy for “Responsive Behaviours” number 09-05-01 dated September 2010 directed staff to use progress notes to document situations when the resident was displaying behaviour, actions taken as well as outcome of the situation. In addition the policy directed staff to complete accurate documentation in the resident’s health record that should include:

a) Any identified triggers to the behaviour;
b) How the behaviour was displayed;
c) What was observed in the immediate surroundings;
d) What interventions were unsuccessful or successful;
f) Additional actions taken by the staff or others; and
g) Any negative experience or outcome for the resident or another person/resident.

During interview, the ADOC stated that staff would review progress notes for residents with consistent or worsening behaviours; the review may trigger a more indepth assessment of residents who exhibited responsive behaviours according to the home’s policy. Registered staff, Behavioural Supports Ontario (BSO) staff, DOC and ADOC

confirmed that resident #012 had not had a more indepth assessment of their behaviours between three months prior to the most recent RAI MDS assessment and this inspection, even though the RAI MDS assessment indicated behavioural symptoms had worsened. The DOC and ADOC confirmed that resident #012’s responsive behaviours and their responses to interventions had not been documented in the resident's health record and the resident had not been assessed further for behaviours according to the home’s policy. [s. 53. (4) (c)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that concerns or recommendations received from the Residents' Council were responded in writing within ten days.

A review of the Residents’ Council Meeting Minutes for the previous 10 months (April 2014 to January 2015) indicated that the dietary concerns were identified during the meetings. There was no documentation to reflect that a written response had been provided regarding these concerns. Interview with the Residents’ Council President confirmed that not all concerns received were responded to in writing within ten days. The Program Manager validated there was no written record of responses to dietary concerns or recommendations received from the council. [s. 57. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

On March 9, 2015, the menu posted in Trafalgar home area dining room indicated on the therapeutic menu that pureed bread was to be served at lunch meal. The bread was not served to all residents at lunch. The bread was served only to those residents who had selected a choice of menu for pureed salami sandwich and green salad. However, residents who were served a quiche and peas were not offered bread. The Food Service Manager and the dietary staff confirmed the bread was not served or offered to all residents. [s. 71. (4)] [s. 71. (4)]

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.