Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 18, 2016	2016_30610a_0010	012228-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET WELLAND ON L3C 1Y5

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

IRENE SCHMIDT (510a), KELLY CHUCKRY (611), ROBIN MACKIE (511)

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): May 25, 26, 27, 30, 31, 2016 and June 1,2,3 and 7, 2016.

During this RQI, follow up to inspection #2015_341583_0012, CO#001, log #H-003377-15 was completed and the order was complied. As well, three Critical Incident's, #015907-15 (duty to protect and reporting), #018038-15 (duty to protect and reporting), 028647-15 (duty to protect and reporting), and one complaint, #036404-15 (transferring and positioning), were inspected.

During the course of the inspection, the inspector(s) spoke with residents, families, personal support staff, registered staff, physiotherapy staff (PT), medical staff (MD), housekeeping staff, maintenance staff, Resident Assessment Instrument (RAI) Coordinator, Program Coordinator, Associate Director of Care (ADOC), Director of Care (DOC) and the Administrator. As well, inspectors toured the facility, reviewed policy, procedures and clinical records and observed the delivery of care and services.

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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

8 WN(s)
5 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. 15. (2)	CO #001	2015_341583_0012	510a

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

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

Specifically failed to comply with the following:

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

s. 6. (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. (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 has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On an identified date, a resident was observed sitting in their wheelchair, in their room. A steady drip of urine from the seat of the wheelchair created a puddle on the floor. This was confirmed by the registered staff. The care plan for the resident directed that staff would change the resident's incontinent product routinely before (ac) meals, and/or after (pc) meals, at bed time (hs) and as necessary (prn)). PSW staff confirmed that the resident's morning routine was to go for a walk immediately after breakfast, which delayed their morning pc change and resulted in the resident's brief being saturated. The RAI coordinator and registered staff reported a voiding diary, to accurately assess the resident's voiding patterns, product need and change schedule, had not been completed and would be initiated. The plan of care was not based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the

resident so that their assessments were integrated and were consistent with and complemented each other.

A) A review of the clinical record of an identified resident, indicated they had an increased risk for altered skin integrity related to impaired mobility, incontinence, desensitized skin, and peripheral vascular disease. A review of recent wound care assessment indicated the resident had tissue impairment in two identified areas. A review of the interdisciplinary care conference documentation on the same date indicated the resident was receiving wound care for different identified areas of skin impairment. B) A review of the minimum data set (MDS) quarterly assessment, for an identified resident, at an identified time, indicated the resident had three areas of skin impairment. A review of the wound assessment for the same time frame and a subsequent MDS assessment, revealed differing assessments of the resident's skin integrity. Interview with the wound care nurse confirmed the registered staff had not collaborated so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care.

An identified resident was admitted to the home in on a specified date. They had multiple medical diagnoses. On two identified dates, the resident experienced distress and underwent treatment in the home. The resident had a history of not complying with medical treatment. The registered staff re-initiated treatment when discontinued by the resident. A review of the medical directives daily documentation, indicated the treatment was not signed for, as administered, for nine days during one episode of illness and 12 days during another episode. A review of the progress notes and, in consultation with the DOC and RAI coordinator, it was identified that the treatment was not documented on the days identified in the electronic Medical Directives Administration Record. Further review of the clinical record, which was confirmed by the DOC and RAI Coordinator, indicated that during both episodes of illness, the resident's outcomes and effectiveness of the treatment were not consistently documented during the resident's illness. [s. 6. (9)]

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 such that plans of care are:
1) based on assessments of all resident's needs and preferences, particularly related to activities of daily living,
2) based on collaboration between staff members in the assessment of residents so that assessments are integrated, consist and complement each other, and
3) that the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the care are documented, to be implemented voluntarily.

WN #2: 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) The licensee's Skin and Wound Care Program, index #MP00-006, implemented November 23, 2003 and revised on April 12, 2016, stated the resident with altered skin integrity would receive immediate treatment and intervention to promote healing. The registered staff would make a referral to the registered dietitian (RD) for any break in

skin, pressure ulcer or skin tear. The RD would then complete a nutrition and hydration risk assessment within seven days of being notified. A review of an identified resident's clinical record indicated a registerd practical nurse (RPN) identified a small area of altered skin integrity, in an identified area, at a specified time. Specific observations about the altered skin integrity were noted. A referral to the RD was sent at a significantly later, identified date. Interview with the RD confirmed they had not received a referral for the identified resident until a later identified date. The RD assessed and completed a nutrition risk screening form on a much later identified date. The RD confirmed the home's practice, based on the policy, would have been for the registered staff to complete an assessment and initiate an RD referral when the altered skin integrity was first identified. The RD would then assess within seven days. Interview with the DOC confirmed the licensee failed to ensure the home's skin and wound care program was complied with when the registered staff did not assess the altered skin integrity or refer the resident to the RD for immediate treatment and intervention related to alteration in skin integrity.

B) A review of the clinical record indicated an identified resident had a wound care assessment completed by registered staff on a specified date, which identified an alteration in skin integrity on an identified area of the resident's body. A referral document to the RD was completed on an identified date, and the RD assessed the resident on a later identified date. Interview with the RD confirmed they documented the assessment as a nutrition progress note, more than a week after they had received the referral. The RD confirmed the home's policy indicated the RD would complete a nutrition and hydration risk assessment with seven days of notification.

C) A review of the clinical record indicated an identified resident had a wound care assessment completed by a registered staff on an identified date, that identified altered skin integrity of an identified area. A referral document to the RD was completed on an identified date, and the RD confirmed they documented the assessment as a nutrition progress note an identified number of days after they had received the referral. The RD confirmed the home's policy indicated the RD would complete a nutrition and hydration risk assessment within seven days of notification.

D) The home's Skin and Wound Care Program stated the registered staff responsible, would notify the care team of the altered skin integrity and document in the multidisciplinary notes that the care team was notified. A review of the clinical record indicated an identified resident had a small red area of altered skin integrity on their body, on an identified date. It was documented by the registered staff that this was a recurring area of altered skin integrity due to positioning. Interview with the care team member confirmed they had not been notified of this area of altered skin integrity. A review of the multidisciplinary notes did not indicate the care team had been notified of

this altered skin integrity, as per home's policy.
E) Review of the clinical record for an identified resident indicated they were at an increased risk for alteration in skin integrity. An initial assessment completed on an identified date, described several areas of altered skin integrity. The assessment indicated the resident had been referred to the RD on an identified date. A review of the home's referral system (Sherpa) indicated there were no referrals sent for the initial areas of altered skin integrity. The clinical record indicated the resident was assessed by the RD on a later identified date, when the resident had developed another area of altered skin integrity. Interview with the RD confirmed they had not received a referral for the resident, when they had initially developed an alteration in skin integrity. The home's policy was not complied with, as a referral to the RD was not made when the alteration in skin integrity was identified. .
F) Seniors Services Policy and Procedures, index #MP00-002, titled Falls Prevention Program, implemented April 5, 2011, and revised May 11, 2016, directed that:
1. registered staff would make referrals to other disciplines as needed (occupational therapy (OT), physio therapy (PT), medical staff (MD), etc)
2. physical and occupational therapists would assess any resident who had fallen upon request/referral.
The initial fall risk assessment for an identified resident, on an identified date, reported the resident to be at high risk for falls. The resident was fall free until an identified date when, over the course of an identified time frame, the resident experienced a number of falls. The most recent fall resulted in injury. Registered staff and the physiotherapist (PT) confirmed that weekly fall meetings were attended by nursing and PT and that referrals to other disciplines could be made verbally at the time of the inter-disciplinary meeting or through an on line referral process (Sherpa). Staff reported that verbal referrals would be documented in the progress notes for the weekly fall meeting. Review of the clinical record revealed the absence of a referral from registered staff to the PT at the time of the interdisciplinary meetings, or through Sherpa, as set out in policy. This was confirmed by registered staff, PT and RAI coordinator. The home's policy was not complied with. [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 the homes Skin and Wound Care Program direction is complied with, especially as it relates to assessments and referrals to appropriate team members, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

An identified resident experienced a moderate level of cognitive impairment. On an identified date, an incident of alleged emotional abuse occurred between an identified staff member and the identified resident, was reported to the home. The allegation reported that the resident was approached by staff in an aggressive manner. The resident described how the staff member interacted with them and was consistently able to describe the events of the identified date, on four separate occasions, to four different people, including their Substitute Decision Maker (SDM) and 3 staff members.
An interview with the Administrator confirmed the incident was abusive in nature. The home failed to protect the resident from emotional abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, that was complied with.

The licensee's Abuse and Neglect-Zero Tolerance policy, # RR00-001, implemented on July 7, 1994, and revised on July 30, 2014, indicated the registered staff would assess the resident from head to toe and document the assessment in the resident's progress notes, when an allegation of improper or incompetent treatment or care of a resident, that resulted in harm or a risk of harm, was received. A review of the critical incident (CI) that was submitted to the Director on an identified date, alleged abuse of a resident. The CI further indicated there was no harm from the incident. A review of the resident's clinical record indicated there was no head to toe assessment completed by the registered staff to confirm the statement that there was no harm to the resident. Interview with the Administrator confirmed that when the allegation was made, a head to toe assessment was not completed. The home's policy for Abuse and Neglect was not complied with. [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 the home's policy #RR00-001, titled Abuse and Neglect - Zero Tolerance, is complied with, particularly that, when an allegation of abuse is received, a head to toe assessment of the resident is completed by a member of the registered staff and the same is documented in the resident's progress notes, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident.

On an identified date, the licensee received a document, that provided information and interview statements in response to an incident which was alleged to have occurred in the home on an identified date. Provided in this document, were statements that indicated that on an identified date and time, an identified resident had been treated in a neglectful, abusive manner by three identified staff. Interview with the three identified staff members, confirmed they had not been interviewed by the licensee regarding the interactions that were alleged to have occurred on the identified date. [s. 23. (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, every alleged, suspected or witnessed incident, of (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #6: 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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person simultaneously assisted more than two residents who needed total assistance with eating or drinking.

A lunch meal service was observed on an identified date. According to their current care plans, three identified residents, all required total assistance from a staff member to complete all tasks of eating. A staff member was observed to simultaneously provide this assistance to all three residents and moved between two tables, on a feeding chair on wheels. Staff confirmed this happened frequently on the unit, particularly when the RN was not available to provide assistance in the dining room.
An interview with the ADOC confirmed that staff members should only provide assistance to two residents who need total assistance with eating or drinking, at the same time . [s. 73. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations. The required information for the purposes of subsection (1) and (2) is, (k) copies of the inspection reports from the past two years for the long term care home.

The resident and family information board located in the hallway outside the elevator contained the required postings for the home. A review of the inspection reports posted revealed that two reports were not posted, as required. A Resident Quality Inspection (RQI) report, inspection #2015_341583-0012 and a complaint inspection report, inspection #2015_248214_0012, were not posted.
The ADOC confirmed these reports were not posted as required. [s. 79. (3) (k)]

WN #8: 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 has failed to ensure that the resident's Substitute Decision Maker (SDM), if any, and any other person specified by the resident, (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

An identified resident was assessed to have significant cognitive impairment. According to the critical incident (CI) report, on an identified date, the licensee became aware of an allegation of abuse to the identified resident. The licensee submitted a CI mandatory report to the Director that indicated an allegation of improper/incompetent treatment of a resident had been reported on an identified date. The report indicated the police were notified but the resident's SDM had not been informed or contacted. Interview with the Administrator confirmed the SDM had not been notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

Issued on this 11th day of August, 2016

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

Original report signed by the inspector.