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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 2, 2017	2017_546585_0001	000263-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

TALL PINES LONG TERM CARE CENTRE
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

LEAH CURLE (585), GILLIAN TRACEY (130), ROBIN MACKIE (511), THERESA MCMILLAN (526)

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): January 6, 9, 10, 12, 13, 16, 18, 19, 20, 23, 24, 2017.

In addition to the RQI, nine concurrent inspections were completed including: one follow-up log #005089-16 regarding skin and wound, six Critical Incident System (CIS) log #010936-16, #017146-16 and #001378-17 related to falls, #011234-16, #16182-16 and #032185-16 regarding alleged abuse as well as two complaints log #013531-16 regarding alleged abuse, nutrition/hydration and resident care and #000776-17 related to resident care and personal support services. Two on-site inquiries were also conducted log #014559-16 and #014503-16 regarding alleged abuse.

During the course of the inspection, the inspector(s) spoke with residents, families, registered nurses, registered practical nurses, personal support workers (PSWs), the Resident Assessment Instrument (RAI) Specialist, Registered Dietitian (RD), Supervisor of Dietary Services, Supervisor of Facility Services (SFS), dietary staff, facilities staff, Supervisors of Care (SOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed care and services provided to residents, reviewed relevant records which included, but was not limited to: resident clinical health records, policies, staff training records and critical incident (CI) investigation records, complaints logs, maintenance logs, program evaluations and compliance order corrective action documentation.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

- **10 WN(s)**
- **2 VPC(s)**
- **2 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
O.Reg 79/10 s. 50. (2)	CO #001	2015_301561_0022	130

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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, that actions were taken and outcomes evaluated. 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status.

The home's policy, "Weight Monitoring System Program", revised April 2016, outlined responsibilities of staff regarding monitoring of weights:

i. Personal Support Workers (PSWs): responsible for all weights in an electronic flow sheet or on form NF-059 – Monthly Weight Record. Weigh the resident at monthly intervals with a consistent schedule using the same scale, by the seventh day of the month. Where a re-weight is necessary, a new weight will be measured and recorded as soon as possible and no later than the tenth day of the month. If the resident requires another weight measurement, measure and record the weight following the same method and scale.
ii. Registered nursing staff: review the weight flow sheet on or about the eighth day of the month to determine need for reweigh, further assessments and referrals. Investigate causes related to weight change and will document any/all assessments in findings related to weight change in the Dietary Requisition/Referral. Refer to the Registered Dietitian (RD) using the Dietary Requisition/Referral in the resident health record for all residents with unplanned weight change that is equal to or greater than 5 per cent (%) in one month, 7.5% or greater within three months and 10% or greater within six months.
iii. Registered Dietitian (RD): will modify the nutritional care plan outlining goals and expected outcomes; the effectiveness of the nutritional care interventions will be evaluated. RD will document the unplanned weight change in the progress notes and document interventions in the nutrition care plan. The RD will assess and document the significant change of greater than 5% in one month, 7.5% in three months, or 10% in six months, unplanned weight change in the progress notes and document the interventions in the nutrition care plan.
iv. The home's Monthly Weight Record form stated the resident must be reweighed by the registered nursing staff if there is a weight loss/gain of 2.2 kilograms (kg) or more from the previous month.

A) Review of resident #010's plan of care stated they were at high nutritional risk related

to identified diagnoses and needs. The plan noted they were at risk for further weight loss related to medical conditions as evidenced by significant weight loss, revised January 2017. The plan included a goal to minimize risk of weight loss/promote weight maintenance and to maintain weight within a specified goal weight range, revised August 2015.

Review of the resident's weight records and progress notes revealed their weight was below their goal range from January 2016 to January 2017.

i) On a specified date in January 2016, the resident's monthly weight triggered a loss of greater than 15 per cent over one, three and six months, including a loss of greater than 2.2 kg over one month. Later in the same month, on a specified date, the RD responded to the weight change as potential scale error and to continue current dietary interventions. No re-weigh was taken by staff in January 2016, as confirmed by the RD and registered staff #120.
ii) On a specified date in February 2016, the RD documented weight loss confirmed and increased the resident's identified nutrition supplement. Actions taken to respond to the January weight loss did not occur until the February 2016, when the loss was verified, as confirmed by the RD.
iii) On a specified date in March 2016, the resident's monthly weight triggered a gain greater than 10 per cent over one month. No re-weigh was recorded when they experienced a gain of greater than 2.2 kg, as confirmed by the RD and registered staff #120.
iv) On a specified date in July 2016, the resident's monthly weight triggered a loss of over 7.5 per cent over three months, which was confirmed by a re-weigh. The RD documented unexplained weight variation, and did not implement any change to nutrition interventions.
v) On a specified date in July 2016, in a Dietary Minimum Data Set (MDS) Resident Assessment Protocol (RAP) Summary, the RD documented undesired weight loss noted over the last quarter despite adequate intake, goal to maintain weight, continue with nutritional supplement order to promote further weight gain; however, in review of the weights, the resident was not experiencing further weight gain at that time, as confirmed by the RD.
vi) On a specified date in August 2016, following a dietary referral for weight loss of greater than 10 per cent over three months, the RD documented unexplained weight variation; resident meeting estimated nutritional needs and recommended no dietary interventions.
vii) On a specified date in December 2016, the resident experienced a weight gain of

over five per cent in one month; however, no referral was sent to the RD, as confirmed by the RD and registered staff #120.
viii) On a specified date in January 2017, in a Dietary MDS RAP Summary, the RD documented the resident's weight remained below goal weight range, continue with current nutritional supplement order.

B) Resident #007's plan of care stated they were at high nutritional risk related to specified diagnoses and requirements, revised October 2016.

i) Review of the resident's clinical record revealed in August 2016, no re-weigh was taken when the resident experienced a weight loss of 2.2 kg in one month, as confirmed by registered staff #120 and the RD.
ii) On a specified date in October 2016, the resident experienced a weight loss of greater than 15 per cent over one, three and six months. Within a week, the RD completed a Dietary MDS RAP supplement note as well as response to a referral for the significant weight change, assessed the resident based on a physical assessment and intake records; documented possible scale errors and requested re-weighs. Review of weight record and interview with registered staff #120 and the RD confirmed no re-weigh was recorded in October 2016.
iii) In November 2016, the resident triggered a weight loss of greater than 15 per cent over one month and loss of over 20 per cent over three months. On a specified date in November 2016, the RD documented unexplained weight variations, please re-weigh resident with calibrated scale. Registered staff #120 and the RD confirmed no re-weigh was recorded.
iv) In December 2016 and January 2017, the resident continued to trigger significant weight changes and re-weighs were completed; however, the RD continued notations regarding scale errors.

C) Resident #005's plan of care stated they were at high nutritional risk related to specified diagnoses and requirements.

i) On a specified date in August 2016, the resident triggered for a weight loss greater than 10 per cent over one month. The RD noted potential scale error; however, initiated a nutritional supplement as per caution.
ii) On a specified date in September 2016, the resident triggered for a weight loss greater than 5 per cent over one month, including a loss exceeding 2.2 kg; however, no re-weigh was completed in September 2016, as confirmed by registered staff #120. Later in the month, the RD documented potential scale error and modified the resident's

nutritional supplement.

Interview with the RD reported they questioned the accuracy of the home's scales for over a year and their concerns remained, as evidenced by continued unexplained weight fluctuations. The RD reported they used food and fluid intake records, staff interviews and a visual assessment of residents to assess triggered weight changes; however, confirmed they could not prove whether or not significant weight changes occurred. The RD reported re-weighs were not always completed when requested via progress notes and in communication to the Supervisors of Care.

Review of referrals from registered nursing staff regarding significant weight changes did not include any documentation of possible reasons for weight changes to support the RD in conducting an accurate assessment. Registered staff #120 confirmed it was not a practice of registered staff to include supplementary information regarding reasons for weight changes. Registered staff #128 reported PSWs completed and recorded any re-weighs, not registered nursing staff. Interview with PSW #119 reported there were issues at times with the scales on the home area functioning properly. Review of the maintenance logs in 2016 for two home areas also revealed multiple requests for the home's maintenance staff (facilities) to service the scales.

The licensee failed to ensure that resident #005, resident #007 and resident #010 were assessed when they experienced weight changes using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

This non-compliance was issued as a result of complaint inspection log #013531-16, which was conducted concurrently with the RQI. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 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 following requirements were 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.

On a specified date in January 2017:

A) Resident #011 was observed with a specified physical device applied. A space of four finger widths was identified between the resident's body and the physical device. Review of the resident's plan of care revealed they used the device as a physical restraint to prevent falls and unsteady gait.

B) Resident #012 was observed with a specified physical device applied. A space greater than five finger widths was identified between the resident's body and the physical device. Review of the resident's plan of care revealed they used the device as a physical restraint to prevent injury, unsteady gait and specified limitations.

C) Resident #013 was observed with a specified physical device applied. A space greater than five finger widths was identified between the resident's body and the physical device. Review of the resident's plan of care revealed they used the device as a physical restraint to prevent injury, decreased strength, unsteady gait and specified limitations.

Supervisor of Care (SOC) #114 reported resident #011, resident #012 and resident #013 used the devices as physical restraints and the home's expectation was that the devices have a space no more than two finger widths space between the resident and the device. Review of the manufacturer's specifications for the devices, as provided by SOC #114, stated they were to be worn tightly fitted at all times. [s. 110. (1) 1.]

Additional Required Actions:

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

WN #3: 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out clear directions to

staff and others who provided direct care to the resident.

Resident #007's Dietary RAP assessment completed by the RD in December 2016, noted a plan to discontinue a specified nutrition intervention. At that time, the RD revised the care plan and kardex, used by registered staff and PSWs to direct care. On a specified date in January 2017, review of the resident's Medication Administration Record (MAR) from January 2017 and orders revealed they were still receiving the nutrition intervention the RD planned to discontinue. The RD confirmed the resident's plan of care did not set out clear direction to staff regarding their nutritional care interventions. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

On a specified date in March 2016, resident #053 was readmitted to the home after hospitalization related to a fall that resulted in injury.

i) A skin assessment completed upon the resident's return from hospital indicated they had altered skin integrity; however, no planned interventions were identified on the written plan of care related to the management of impaired skin integrity.

ii) A pain assessment completed upon their return from hospital and progress notes confirmed the resident was experiencing pain in a specified area; however, there were no planned interventions identified on the written plan of care related to pain management.

iii) An assessment completed by the physiotherapist (PT) on a specified date in March 2016, identified the resident was at high risk for falls. The PT's recommendations to manage fall risk included multiple specified interventions; however, the written plan of care did not identify the need for these interventions.

On January 20, 2017, the Resident Assessment Instrument (RAI) Specialist confirmed the written plan of care was not based on the assessed needs of the resident.

This non-compliance was issued as a result of Critical Incident (CI) inspection log #010936-16, which was conducted concurrently with the RQI. [s. 6. (2)]

3. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an

opportunity to participate fully in the development and implementation of the resident's plan of care.

i) Resident #070's clinical record identified all care decisions were made for them by staff and their SDM. Documentation in the resident's progress notes revealed on a specified date in January 2017, an area of altered skin integrity had developed, which required treatment. No documentation identified that the SDM was notified at the time the resident's plan of care changed. Interview with the registered nurse #114 confirmed the SDM and was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

ii) Resident #003's most recent plan of care indicated they required extensive assistance for all their activities of daily living (ADLs) due to his medical condition. Review of progress revealed the resident experienced changes in their medical condition on two specified dates in January 2017. Documentation had not indicated the SDM was notified or given an opportunity to participate fully in the development and implementation of the resident's plan of care related to the resident's change in condition on the specified dates in January 2017. Interview with the registered nurse #114 confirmed they had not notified resident #003's SDM for the above noted change in condition in January 2017.

This non-compliance was issued as a result of complaint inspection, log #000776-17, which was conducted concurrently with the RQI. [s. 6. (5)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #070's clinical record revealed they required the use of specialized therapeutic intervention. A specified date in January 2017, the resident developed an altered level of skin integrity and the area required treatment. Further investigation from the home's staff, as documented on the home's complaint summary form identified the specialized therapeutic intervention was not applied properly and created discomfort and pressure. A review of the most recent plan of care identified the direction on how the intervention was to be applied. According to the progress notes, on a later date in January 2017, the resident developed an area of altered skin again. Interview with registered staff #114 confirmed ongoing concerns with ensuring the intervention being applied appropriately. The DOC confirmed the licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

This non-compliance was issued as a result of complaint inspection, log #000776-17, which was conducted concurrently with the RQI.

B) On a specified date in November 2016, a CIS (Critical Incident System) report was received by the MOHLTC that identified resident #071 had been left unattended during care.

Resident #071's clinical record identified they had specified diagnoses that included identified limitations, required total assistance from staff for all activities of daily living and at risk for falls. The staff were to ensure their environment was as safe as possible.

Documented statements made by PSW #125 indicated the resident had been left alone while they assisted other residents for an unspecified time period. The home's internal documentation concluded that several staff had checked on the resident frequently and the resident was unharmed and experienced no injuries or ill affects while unattended. Documented statements made by registered staff #126 confirmed they had also checked on resident #071.

Interview with SOC #124 confirmed the resident's clinical condition and direction in the plan of care had not indicated the resident could be left alone and despite the staff completing frequent safety checks, the staff did not follow the resident's plan of care when they had been left unattended for unidentified intervals on a specified date in November 2016.

This non-compliance was issued as a result of CI inspection log #032185-16, which was conducted concurrently with the RQI. [s. 6. (7)]

5. The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A) Resident #010's plan of care stated they were at high nutritional risk related to specified diagnoses and requirements. The plan noted they were at risk for further weight loss related to underlying conditions as evidenced by significant weight loss, revised January 2017, and included a goal to minimize risk of weight loss/promote weight maintenance and to maintain weight within a specified goal weight range (GWR) revised August 2015. Review of the resident's weight record from January 2016 to January 2017 revealed the resident had not achieved their documented GWR range since December

2015. Progress notes during the inspected period revealed the RD had assessed the resident regularly, indicated they were below their GWR; however, documented a goal maintain weight within GWR. The RD reported in an interview the resident's goal had changed to maintain weight and promote weight gain toward their GWR; however, confirmed they did not revise the plan of care when their care needs changed.

This non-compliance was issued as a result of complaint log #013531-16 which was conducted concurrently with the RQI.

B) Resident #005's plan of care stated they were at high nutritional risk related to specified diagnoses and requirements, revised October 2016. The plan included a goal to maintain weight within a specified GWR revised May 2015. Review of the resident's weight record in January 2017, revealed they had consistently been below their GWR since July 2016. Progress notes between July 2016 to January 2017 revealed the RD had assessed the resident regularly, indicated they were below their GWR; however, documented a goal maintain weight within GWR. The RD reported the resident's goal had changed to prevent further weight loss and promote weight gain toward their GWR; however, confirmed they did not revise the plan of care when their care needs changed.

C) On specified dates in January 2017, resident #007 was observed receiving total assistance with eating by PSWs. Interview with PSW #102 reported the resident required to extensive to total assistance and required specified interventions at meal time. Review of their plan of care stated they required extensive assistance with eating and indicated different specified interventions than what was observed and reported by PSW #102. Point of Care (POC) documentation between an identified period in January 2017, revealed they required total assistance with eating 50 per cent of the time. Interview with the RD confirmed the resident's plan of care was not reviewed and revised when the their care needs changed related to eating.

D) On a specified date in March 2016, resident #053 sustained a fall, which resulted in injury.

i) On a specified date in March 2016, a Significant Change in Condition Assessment was completed for the resident and identified a deterioration in their condition and changes to multiple personal domains; however, there were no objectives specified in the RAPs and no revisions made to the written plan of care to address the changes to any of the identified areas.

ii) On a specified date in April 2016, progress notes indicated the resident's condition had worsened and new care orders were obtained. The resident required new therapeutic interventions be administered.

On January 20, 2017, the RAI Specialist confirmed the written plan of care was not updated to include the change in the resident's condition nor the change to therapeutic interventions.

This non-compliance was issued as a result of CI inspection log #010936-16, which was conducted concurrently with the RQI.

E) According to resident #003's clinical record, they experienced two new episodes of ill symptoms on two specified dates in January 2017. The Registered Nurse documented the resident required monitoring. Review of the most recent plan of care did not include the resident's two episodes of ill symptoms, related to an identified condition, as documented. Interview with DOC confirmed the resident had not reassessed and the plan of care reviewed and revised when their care needs changed in relation to their alleged diagnosis.

This non-compliance was issued as a result of complaint log #000776-17, which was conducted concurrently with the RQI. [s. 6. (10) (b)]

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

On an identified date in March, 2016, resident #053 sustained a fall which resulted in an injury.

The resident's plan of care noted they were at high risk for falls since September 2015. Their clinical record confirmed they sustained multiple falls between November 2015 and February 2016. There were no fall management strategies specified in the RAPs and no new strategies identified in the revisions to the plan of care, after the identified falls.

On January 20, 2017, the RAI Specialist confirmed that the written plan of care in place for the management of falls from November 2015 to February 2016, had not been effective in the prevention of falls and that new approaches had not been considered and implemented until after the resident sustained a fall with injury on an identified date in

March 2016.

This non-compliance was issued as a result of CI inspection log #010936-16, which was conducted concurrently with the RQI. s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; the plan of care is based on an assessment of the resident and the needs and preferences of that resident; the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; the care set out in the plan of care is provided to the resident as specified in the plan; the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary,and; when a resident is reassessed and the plan of care reviewed and revised if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

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 where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

A) In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) requires every licensee of a long-term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The home's "Skin and Wound Care Program", last revised June 27, 2016, directed PSWs to do a visual head to toe skin assessment on bath days and document on the resident's electronic health record.

On a specified date in January 2017, resident #003 was observed to have an area of altered skin. According to their health record, they were at risk for alteration in skin integrity; however, their clinical record did not indicate that the area of altered skin integrity had been documented or assessed. PSW #109 reported they observed the area on an earlier date in January 2017; however, did not document the observation or report the issue to the registered staff. PSW #109 and registered staff #105, who was the home's skin and wound champion, indicated PSW staff were expected to inform registered staff if they found an alteration in skin integrity. Registered staff #105 confirmed that the home's Skin and Wound Care Program had not been complied with when PSW #109 did not document or inform registered staff of the resident's alteration of skin integrity when they initially observed it.

B) In accordance with O. Reg. 79/10, r. 68 (2)(e)(ii) requires every licensee of a long-term care home to have a weight monitoring system to measure and record with respect to each resident body mass index and height upon admission and annually thereafter.

The home's policy, "Nutrition Assessment and Risk Identification, Policy No. LTC 4-5.7", effective March 26, 2007, stated heights would be recorded on admission. In supplement to this policy, to meet the requirements set out in r. 68 (2)(e)(ii), the DOC reported the home implemented training and direction in 2014 to registered staff as well as written direction to measure residents' heights annually and document immediately in POC.

Review of resident clinical records revealed annual heights for 2016 were not completed for resident #005, resident #007 and resident #010. Registered staff #120 reported resident #005, resident #007 and resident #010's most recent heights were measured in 2015. The DOC confirmed the home's expectation as per their procedure was for heights to be measured annually.

This non-compliance was issued as a result of complaint inspection log #013531-16, which was conducted concurrently with the RQI.

C) In accordance with O. Reg. 79/10, r. 30. (1) requires every licensee of a long-term care home to ensure that the following is complied with in respect to each other of the organized programs required under sections 8 to 16 of the Act: s. 8 (1)(b) an organized program of personal support services for the home to meet the needs of the residents.

i) The home's policy, "Care Carts/Caddies/Care Bag - Policy No: LTC9-07.07", effective April 5, 2011, stated personal care items such as toothbrushes, combs, brushes are to be labelled and stored in the resident room. The mandate of the policy indicated it was in accordance with the Long Term Care Homes Act, 2007 (s. 8) and O. Reg. 79/10 (s.44).

On identified dates in January 2017, the following unlabelled and used personal care items were found in the spa and tub rooms on Pinerose Court and Humber Court and Mayfield Court: nail brushes with hair, combs, hair brushes, a nail clipper, and solid deodorant sticks. Registered staff #107 confirmed the unlabelled personal items were not to be stored in the shower/spa rooms.

ii) The home's policy, "Soiled Linen Carts - Policy No: LTC9-07.08", effective November 4, 2010, stated soiled laundry is to be placed in the appropriate coloured laundry bag, as parked on the lid of the soiled laundry cart. The mandate of the policy indicated it was in accordance with the Long Term Care Homes Act, 2007 (s. 8) and O. Reg. 79/10 (s.89).

On January 6, 2017, soiled laundry was observed lying on the floor in front of a resident room on a first floor home area where contact precautions were in place. PSW #102 indicated that the laundry belonged to the resident without contact precautions in place. Registered staff #107 confirmed soiled laundry was not to be stored on the floor.

D) In accordance with O. Reg. 79/10, r. 48. (1) requires every licensee of a long-term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the

incidence of falls and the risk of injury.

The home's "Fall Prevention and Management Program", revised October 24, 2016, indicated:
"1. Assess residents using the Morse Falls Risk Assessment (electronic health record tool): i. within 24 hours of admission and readmission".

i) On a specified date in March 2016, resident #053 was readmitted to the home. Review of the clinical record indicated no Morse Falls Risk Assessment was completed within 24 hours of readmission. The DOC confirmed on January 24, 2017, that a Morse Falls Risk Assessment was not completed upon readmission from hospital. This non-compliance was issued as a result of CI inspection log #010936-16, which was conducted concurrently with the RQI.

ii) On a specified date in January 2017, resident #001 was readmitted to the home. Review of the clinical record indicated no Morse Falls Risk Assessment was completed within 24 hours of readmission. The DOC confirmed on January 24, 2017, that a Morse Falls Risk Assessment was not completed upon readmission from hospital. This non-compliance was issued as a result of CI inspection log #001378-17, which was conducted concurrently with the RQI. [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 and ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place in accordance with all applicable requirements under the Act is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On a specified date in March 2016, resident #053 sustained a fall, which resulted in an injury.

According to the progress notes during a specified period in April 2016, the resident received a specified intervention multiple times as per a physician's order. Review of the resident's MAR did not include the order for the specified intervention nor was there documentation on the MAR of the intervention being administered. This information was confirmed by the DOC on January 24, 2017.

This non-compliance was issued as a result of CI inspection log #010936-16, which was conducted concurrently with the RQI. [s. 30. (2)]

WN #6: 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 a resident 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.

On a specified date in January 2017, a PT note identified resident #070 developed an altered level of skin integrity. The wound required treatment and pain medication. According to the progress notes, on a later date in January 2017, the wound area was found to be open again. Review of the clinical record did not indicate a skin assessment was completed by the registered staff using a clinically appropriate tool. Interview with registered staff #114 confirmed there was no skin assessment completed by the registered staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

This non-compliance was issued as a result of complaint inspection log #000776-17, which was conducted concurrently with the RQI. [s. 50. (2) (b)]

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

On a specified date in April 2016, the Skin and Wound Assessment completed for resident #009 indicated they had newly identified area of altered skin integrity. The affected area was reassessed weekly on three out of five occasions between April and May 2016.

On a specified date in November 2016, the Skin and Wound Assessment for resident #009 indicated they had multiple areas of impaired skin integrity. One affected area was not reassessed for a period of three weeks in November 2016, and according to the Skin and Wound Assessments, an additional area of altered skin integrity that was previously identified with alteration was not reassessed after a specified date in November 2016.

The RAI Coordinator confirmed that not all of the identified areas of impaired skin integrity were consistently reassessed weekly, as required. [s. 50. (2) (b) (iv)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. Subsection 219. (1) of O. Reg. 79/10 defines intervals for the purpose of subsection 76(4) of the Act to be completed at annual intervals.

The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

On a specified date in January 2017, three loose restraints were observed applied to resident #011, resident #012 and resident #013. Training records of staff working on the home area during the shift the day the loose restraints were observed revealed one PSW did not receive annual education in 2016 on how to restrain residents in accordance with the requirements for restraining set out in the Act and regulations. The DOC confirmed that 15.2% of direct care staff did not receive annual training in 2016 on minimizing of restraints. [s. 76. (7) 4.]

WN #8: 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 has failed to ensure that procedures were developed and implemented for cleaning of the home, including, common areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On January 6 and 9, 2017, a foul smell was identified in the Humber Court home area solarium. On closer inspection, pest control devices were noted on the floor with bait material and mouse droppings densely scattered around the devices, in the corners, along the wall, and on window sills of solariums on Humber Court and Pinerose Court home areas.

During a cleaning of the solarium on January 10, 2017, the Supervisor of Facility Services (SFS) and housekeeping staff #103 confirmed three mouse carcasses were present within and under cabinetry located in the Humber Court home area solarium. Mouse droppings were discovered in and under cabinetry and shelving.

During interview on January 10, 2017, the SFS provided documentation that the home had a pest control program and indicated that a licensed pest control vendor provided service in the home on a preventative and as needed basis. Most recently, the pest control vendor provided service in the home for control of the mouse infestation on December 3, 13, 20, 2016, and January 3, 2017. While the vendor addressed the bait devices, they were not contracted to remove debris or mouse droppings.

The SFS stated the home did not have procedures or a schedule in place for routine or

deep cleaning of the solariums; bait debris, mouse droppings and mouse carcasses were not removed since early in December 2016. The SFS stated that a new process for routine and deep cleaning of the solariums had been developed and would be implemented in the immediate future; however, confirmed procedures for cleaning the solariums had not been developed or implemented prior to and at the time of this inspection.

B) As part of the home's housekeeping program, a cleaning routine was developed for the cleaning of resident washrooms, to clean toilets and commodes daily as outlined in housekeeping job routines.

On a specified date in January 2017, at approximately 1100 hours, resident #001's shared washroom was inspected and found unclean, including the toilet and commode. Contact precaution signage was also observed outside the semi-private bedroom. At 1415 hours, interview with housekeeper #108 confirmed the shared toilet and commode was not cleaned as required as part of the home's daily cleaning routine.

C) As part of the home's housekeeping program, a cleaning routine was developed for the cleaning of hallways, as reported by housekeeping staff #115 and the SFS. The responsibilities were also outlined in the housekeeping job routines, to be completed daily.

On January 10, 2017, at 1050 hours, debris was observed on the floor throughout the Woodhill Court home area common hallway, that included but was not limited to: dry solid food debris and crumbs, dried food fluid and lint. Two days later, on January 12, 2017, at approximately 1400 hours, the same debris was found on the floor. The SFS confirmed the home's procedures for cleaning of common areas was not implemented. [s. 87. (2) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and any significant change in resident's condition, either decline or improvement, to be reassessed along with RAPs by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred. The licensee did not comply with the conditions to which the licence was subject for the following identified resident:

i) On a specified date in February 2016, the MDS RAI Assessment completed for resident #053 did not have a triggered RAP for falls despite coding indicating the resident had sustained a fall in the last 30 days. On January 20, 2017, the RAI Specialist confirmed this information.

ii) On a specified date in March 2016, a Significant Change in Status (decline) Assessment was completed for resident #053. The assessment indicated nine out of 17 triggered RAPs stated "no objectives specified", despite a deterioration and/or change, including the Falls RAP, which was the cause of the Significant Change in Status, related to a fall with injury. On January 20, 2017, the RAI Specialist confirmed this information.

This non-compliance was issued as a result of the inspection of CI inspection log #010936-16, which was conducted concurrently with the RQI. [s. 101. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On January 12, 2017, at 1253 hours, an unlocked medication cart was observed by inspector #130 and inspector #585, unattended on the Pinerose Court home area. [s. 130. 1.]

Issued on this 13th day of February, 2017

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

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

Ministére 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), GILLIAN TRACEY (130), ROBIN MACKIE (511), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2017_546585_0001
Log No. / Registre no:	000263-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 2, 2017
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF PEEL 10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	TALL PINES LONG TERM CARE CENTRE 1001 Peter Robertson Blvd., BRAMPTON, ON, L6R-2Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rejane Dunn

To THE REGIONAL MUNICIPALITY OF PEEL, 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 :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that:

A) Residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status.

B) All staff who participate in the assessment, actions and evaluation of weights receive re-education on their roles and responsibilities to meet the requirements of set out under r. 69., including education on how to use scales to ensure accurate weights are recorded as well as the home's procedure for obtaining, recording and documenting re-weighs.

C) Processes and schedules are developed and implemented for:
i) monitoring staff compliance with and ensuring that weights and re-weighs recorded and documented in accordance with the requirements set out in home's Weight Monitoring System Program
ii) preventative maintenance checks for all scales to ensure calibration and accurate weights.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of "minimal harm or potential for actual harm", a scope of "widespread" and a compliance history of "one or more unrelated non-compliance in last three years".

2. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, that actions were taken and outcomes evaluated. 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status.

The home's policy, "Weight Monitoring System Program", revised April 2016, outlined responsibilities of staff regarding monitoring of weights:

i. Personal Support Workers (PSWs): responsible for all weights in an electronic flow sheet or on form NF-059 – Monthly Weight Record. Weigh the resident at monthly intervals with a consistent schedule using the same scale, by the seventh day of the month. Where a re-weight is necessary, a new weight will be measured and recorded as soon as possible and no later than the tenth day of the month. If the resident requires another weight measurement, measure and record the weight following the same method and scale.
ii. Registered nursing staff: review the weight flow sheet on or about the eighth day of the month to determine need for reweigh, further assessments and referrals. Investigate causes related to weight change and will document any/all assessments in findings related to weight change in the Dietary Requisition/Referral. Refer to the Registered Dietitian (RD) using the Dietary Requisition/Referral in the resident health record for all residents with unplanned weight change that is equal to or greater than 5 per cent (%) in one month, 7.5% or greater within three months and 10% or greater within six months.
iii. Registered Dietitian (RD): will modify the nutritional care plan outlining goals and expected outcomes; the effectiveness of the nutritional care interventions will be evaluated. RD will document the unplanned weight change in the progress notes and document interventions in the nutrition care plan. The RD will assess and document the significant change of greater than 5% in one month, 7.5% in three months, or 10% in six months, unplanned weight change in the progress notes and document the interventions in the nutrition care plan.
iv. The home's Monthly Weight Record form stated the resident must be reweighed by the registered nursing staff if there is a weight loss/gain of 2.2 kilograms (kg) or more from the previous month.

A) Review of resident #010's plan of care stated they were at high nutritional risk related to identified diagnoses and needs. The plan noted they were at risk for further weight loss related to medical conditions as evidenced by significant weight loss, revised January 2017. The plan included a goal to minimize risk of weight loss/promote weight maintenance and to maintain weight within a specified goal weight range, revised August 2015.

Review of the resident's weight records and progress notes revealed their weight was below their goal range from January 2016 to January 2017.

i) On a specified date in January 2016, the resident's monthly weight triggered a loss of greater than 15 per cent over one, three and six months, including a loss of greater than 2.2 kg over one month. Later in the same month, on a

specified date, the RD responded to the weight change as potential scale error and to continue current dietary interventions. No re-weigh was taken by staff in January 2016, as confirmed by the RD and registered staff #120.
ii) On a specified date in February 2016, the RD documented weight loss confirmed and increased the resident's identified nutrition supplement. Actions taken to respond to the January weight loss did not occur until the February 2016, when the loss was verified, as confirmed by the RD.
iii) On a specified date in March 2016, the resident's monthly weight triggered a gain greater than 10 per cent over one month. No re-weigh was recorded when they experienced a gain of greater than 2.2 kg, as confirmed by the RD and registered staff #120.
iv) On a specified date in July 2016, the resident's monthly weight triggered a loss of over 7.5 per cent over three months, which was confirmed by a re-weigh. The RD documented unexplained weight variation, and did not implement any change to nutrition interventions.
v) On a specified date in July 2016, in a Dietary Minimum Data Set (MDS) Resident Assessment Protocol (RAP) Summary, the RD documented undesired weight loss noted over the last quarter despite adequate intake, goal to maintain weight, continue with nutritional supplement order to promote further weight gain; however, in review of the weights, the resident was not experiencing further weight gain at that time, as confirmed by the RD.
vi) On a specified date in August 2016, following a dietary referral for weight loss of greater than 10 per cent over three months, the RD documented unexplained weight variation; resident meeting estimated nutritional needs and recommended no dietary interventions.
vii) On a specified date in December 2016, the resident experienced a weight gain of over five per cent in one month; however, no referral was sent to the RD, as confirmed by the RD and registered staff #120.
viii) On a specified date in January 2017, in a Dietary MDS RAP Summary, the RD documented the resident's weight remained below goal weight range, continue with current nutritional supplement order.

B) Resident #007's plan of care stated they were at high nutritional risk related to specified diagnoses and requirements, revised October 2016.

i) Review of the resident's clinical record revealed in August 2016, no re-weigh was taken when the resident experienced a weight loss of 2.2 kg in one month, as confirmed by registered staff #120 and the RD.
ii) On a specified date in October 2016, the resident experienced a weight loss

of greater than 15 per cent over one, three and six months. Within a week, the RD completed a Dietary MDS RAP supplement note as well as response to a referral for the significant weight change, assessed the resident based on a physical assessment and intake records; documented possible scale errors and requested re-weighs. Review of weight record and interview with registered staff #120 and the RD confirmed no re-weigh was recorded in October 2016.
iii) In November 2016, the resident triggered a weight loss of greater than 15 per cent over one month and loss of over 20 per cent over three months. On a specified date in November 2016, the RD documented unexplained weight variations, please re-weigh resident with calibrated scale. Registered staff #120 and the RD confirmed no re-weigh was recorded.
iv) In December 2016 and January 2017, the resident continued to trigger significant weight changes and re-weighs were completed; however, the RD continued notations regarding scale errors.

C) Resident #005's plan of care stated they were at high nutritional risk related to specified diagnoses and requirements.

i) On a specified date in August 2016, the resident triggered for a weight loss greater than 10 per cent over one month. The RD noted potential scale error; however, initiated a nutritional supplement as per caution.
ii) On a specified date in September 2016, the resident triggered for a weight loss greater than 5 per cent over one month, including a loss exceeding 2.2 kg; however, no re-weigh was completed in September 2016, as confirmed by registered staff #120. Later in the month, the RD documented potential scale error and modified the resident's nutritional supplement.

Interview with the RD reported they questioned the accuracy of the home's scales for over a year and their concerns remained, as evidenced by continued unexplained weight fluctuations. The RD reported they used food and fluid intake records, staff interviews and a visual assessment of residents to assess triggered weight changes; however, confirmed they could not prove whether or not significant weight changes occurred. The RD reported re-weighs were not always completed when requested via progress notes and in communication to the Supervisors of Care.

Review of referrals from registered nursing staff regarding significant weight changes did not include any documentation of possible reasons for weight changes to support the RD in conducting an accurate assessment. Registered

staff #120 confirmed it was not a practice of registered staff to include supplementary information regarding reasons for weight changes. Registered staff #128 reported PSWs completed and recorded any re-weighs, not registered nursing staff. Interview with PSW #119 reported there were issues at times with the scales on the home area functioning properly. Review of the maintenance logs in 2016 for two home areas also revealed multiple requests for the home's maintenance staff (facilities) to service the scales.

The licensee failed to ensure that resident #005, resident #007 and resident #010 were assessed when they experienced weight changes using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

This non-compliance was issued as a result of complaint inspection log #013531 -16, which was conducted concurrently with the RQI. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall ensure that:

A) 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.

B) As required under subsection 76 (4) of the Long-Term Care (LTC) Homes Act, 2007, all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training annually on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the LTC Homes Act, 2017 and O. Reg 79/10.

C) Routine audits are conducted to ensure all restraints are applied appropriately and corrective action taken as required.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of "minimal harm or potential for actual harm", a scope of "widespread" and a compliance history of "one or more related non-compliance in last three years".

2. The licensee failed to ensure that the following requirements were 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.

On a specified date in January 2017:

A) Resident #011 was observed with a specified physical device applied. A space of four finger widths was identified between the resident's body and the physical device. Review of the resident's plan of care revealed they used the device as a physical restraint to prevent falls and unsteady gait.

B) Resident #012 was observed with a specified physical device applied. A space greater than five finger widths was identified between the resident's body and the physical device. Review of the resident's plan of care revealed they used the device as a physical restraint to prevent injury, unsteady gait and specified limitations.

C) Resident #013 was observed with a specified physical device applied. A space greater than five finger widths was identified between the resident's body and the physical device. Review of the resident's plan of care revealed they used the device as a physical restraint to prevent injury, decreased strength, unsteady gait and specified limitations.

Supervisor of Care (SOC) #114 reported resident #011, resident #012 and resident #013 used the devices as physical restraints and the home's expectation was that the devices have a space no more than two finger widths space between the resident and the device. Review of the manufacturer's specifications for the devices, as provided by SOC #114, stated they were to be worn tightly fitted at all times.

3. The licensee failed to ensure that as required under subsection 76 (4) of the Long-Term Care (LTC) Homes Act, 2007, all staff who provided direct care to residents are to received, as a condition of continuing to have contact with residents, training annually on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the LTC Homes Act, 2017 and O. Reg 79/10.

On a specified date in January 2017, three loose restraints were observed

applied to resident #011, resident #012 and resident #013. Training records of staff working on the home area during the shift the day the loose restraints were observed revealed one PSW did not receive annual education in 2016 on how to restrain residents in accordance with the requirements for restraining set out in the Act and regulations. The DOC confirmed that 15.2% of direct care staff did not receive annual training in 2016 on minimizing of restraints. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 04, 2017

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
Long-Term Care Inspections 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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 2nd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

Service Area Office /
Bureau régional de services : Hamilton Service Area Office