Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 05, 2018;	2017_547591_0015 (A2)	021171-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

MALTON VILLAGE LONG TERM CARE CENTRE
7075 Rexwood Road MISSISSAUGA ON L4T 4M1

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

NATASHA JONES (591) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please note the following amendments made to the report:

1) CO #002 - s.50(2) - the compliance date was granted an extension from February 28, 2018 to April 30, 2018
2) CO #003 - s.6(10) - the compliance date was granted an extension from February 28, 2018 to April 30, 2018
3) CO #005 - s.221(2) - the wording was revised to reflect necessary changes required in the dates considering the fact that the report was delivered to the home in 2018
4) CO #001 - s.101(3) - the non-compliance was originally issued under s.100(3); however, after review was rescinded and moved to s.101(3).

Issued on this 7 day of February 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

NATASHA JONES (591) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 31, September 1, 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, and 20, 2017.

The following Critical Incident System inspections were completed concurrently with this inspection:

- Log #000622-16 - Staff to resident abuse

- Log #000830-16 - Resident to resident abuse

- Log #007666-16 - Fall and fracture

- Log #012109-16 - Unexplained fracture

- Log #012822-16 - Resident to resident abuse

- Log #025745-16 - Fall and fracture

- Log #005469-17 - Fall and fracture

- Log #014627-17 - Resident to resident abuse

- Log #015082-17 - Fall and fracture

- Log #019503-17 - Fall and injury

- Log #017953-17 - Fall and fracture

The following Complaint inspections were completed concurrently with this inspection:

- Log #014038-17 - care concerns

- Log #019258-17 - care concerns

- Log #012041-17 - care concerns

- Log #012841-17 - care concerns

The following Follow-Up inspections were completed concurrently with this inspection:

- Log #014038-17 - Order #1 - O. Reg 79/10 s. 68(2) -nutrition care and hydration programs

- Log #014040-17 - Order #2 - LTCHA, 2007 S.O. 2007, c.8, s.6 (7) -plan of care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOCs), Program Support Nurse, Dietary Services Supervisor, Dietitian, Facility Services Supervisor, Social Worker, RAI Coordinator, Physiotherapist (PT), Project Manager, registered staff, Behavioural Supports of Ontario (BSO) staff, personal care aides (PCAs), Residents, substitute decision makers (SDMs) and family members.

During the course of the inspection, the inspector(s) toured the home, observed meal services, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes, health care records and

relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Dining Observation

Falls Prevention

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
11 WN(s)
4 VPC(s)
6 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. 6. (7)	CO #002	2017_642606_0008	591
O.Reg 79/10 s. 68. (2)	CO #001	2017_642606_0008	583

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of the home's policy #LTC1-05.01, titled "Prevention, Reporting and Elimination of Abuse/Neglect", last updated June 27, 2016, indicated the home shall treat every allegation of abuse and/or neglect as a serious matter and investigate; take corrective action against those who have abused and/or neglected a resident.
Record review revealed resident #095 sustained an unwitnessed fall in their room in July 2017, which resulted in am injury. The documentation revealed registered staff #119 removed a device in use by the resident prior to the fall. The following day, the resident was found on the floor in their room, complaining of pain.
In an interview, registered staff #116 indicated that at the time of the fall, it was noted that the device had been removed by registered staff #119, who documented its removal. Registered staff #116 confirmed the device should not have been removed as the resident was as the resident was known to require it for their safety, and was a high risk for falls related to their medical condition.known to get out of bed independently and was a high risk for falls related to cognitive impairment.
Record review revealed that resident #095 sustained a fall in June 2017, where they sustained an injury. The resident had been assessed as a high risk for falls. An assessment by the Physiotherapist in June 2017, included a recommendation

to implement a device, as a falls prevention strategy.
A review of the resident's written plan of care directed staff to ensure the device was in place and working when indicated.
In an interview, the Physiotherapist (PT) indicated they first received a referral and assessed resident #095 after they had sustained an injury as a result of a fall in June 2017. Several recommendations related to falls prevention were provided by the PT. The PT further indicated the device should not have been removed by staff prior to the fall
and injury sustained by the resident in July 2017. The PT confirmed that their recommendations related to falls prevention strategies were not implemented as assessed.
The SOC confirmed the PT's recommendations were not implemented, and further, the home failed to follow-up with registered staff #119 related to their identified misconduct.
The home failed to ensure that resident #095 was not neglected by staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee failed to ensure that every order made under the Act and regulations was complied with.

It was a condition of every licensee that the licensee shall comply with this Act, the regulations, and every order made or agreement entered into under this Act and those Acts.

The home was issued a compliance order on June 2, 2017 for O. Reg. 79/10, s. 68 (2) and were directed to ensure that the nutrition care and hydration programs included a system to monitor and evaluate the fluid intake of residents with identified risks. As part of the compliance order it was identified that staff were to be retrained on any new processes implemented, re-educate staff on minimum standards of daily fluid, serving volumes of fluid and re-educate registered staff on the process for monitoring and documenting for signs and symptoms of dehydration.
Through information provided by the Dietary Services Supervisor and the DOC, it was identified training was provided to staff through a combination of course completion done online with Surge learning titled "Hydration Program 2017" and hydration education in services held in the home.
In attendance records provided by the home it was identified that 129 out of 163 required staff received the training. In an interview with the DOC on September 13, 2017, it was confirmed that 21 percent of the staff in the home did not receive the required education on the homes hydration program.
It was confirmed with the DOC, September 20, 2017, that the compliance order issued on June 2, 2017 for O. Reg. 79/10, s. 68 (2), specific to training was not complied with. (583) [s. 101. (3)]

Additional Required Actions:

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

WN #3: 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 :

(A1)
1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received (i) a skin assessment by
a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In July 2017, resident #140 was involved in an incident, and as a result, obtained an injury. A progress note by registered staff #119 indicated that the resident was transferred out for assessment and treatment of the injury. In an interview, registered staff #116 indicated that when a resident had a change in skin condition, the resident's injury must be assessed initially and on a weekly basis thereafter until the wound was resolved. A review of the resident's assessments in Point Click Care (PCC) did not indicate that an initial assessment or any weekly assessments had been conducted for the resident's injury with the use of a clinically appropriate assessment instrument.
A review of the home's policy titled, "Skin and Wound Care Program", last revised

June 27, 2016, indicated
that, "upon identification of altered skin integrity (pressure ulcer, skin tear, wound, burn, rash, abrasion, surgical wound, laceration, bruise etc.), [registered staff] initiate a baseline assessment using the Skin and Wound Assessment on PCC, and weekly until resolved".
In an interview, SOC #270 confirmed that registered staff failed to complete initial and weekly skin and wound assessments for resident #140 with the use of an appropriate skin and wound assessment tool.
[s. 50. (2)(b) (619)

2. In April 2016, resident #029 was involved in an incident and obtained an injury. A review of the progress notes indicated that in April 2016, the resident was seen by the home's physician and was subsequently sent out for an assessment and it was confirmed that the resident had an identified injury as a result of the incident.
In an interview, registered staff #116 indicated that when a resident had a change in skin condition it was the expectation that the resident's injury must be assessed initially and on a weekly basis thereafter until the wound is resolved.
A review of the resident's assessments in PCC did not indicate that an initial skin assessment or any weekly follow up skin assessments had been conducted related to the resident's injury. A review of the home's policy titled, "Skin and Wound Care Program", last revised June 27, 2016, indicated that, "upon identification of altered skin integrity (pressure ulcer, skin tear, wound, burn, rash, abrasion, surgical wound, laceration, bruise etc.), [registered staff] initiate a baseline assessment using the Skin and Wound Assessment on PCC, and weekly until resolved".
In an interview, SOC #270 confirmed that registered staff failed to complete initial and weekly skin and wound assessments for resident #140 with the use of an appropriate skin and wound assessment tool. [s. 50. (2) (b) (619)

3. In January 2016, resident #131 obtained an injury. A review of the resident's progress notes indicated that the resident was assessed by registered staff and sent out for further assessment and treatment. According to the progress notes, the resident returned to the home on an identified day in January 2016, with treatment for their injury. A review of the resident's assessments did not indicate that an initial skin assessment and any weekly skin assessments were completed upon the resident's return to the home.
In an interview, registered staff #116 indicated that when a resident had a change in skin condition that the resident's injury must be assessed initially and on a weekly basis thereafter until the wound was resolved.
A review of the resident's assessments in PCC did not indicate that an initial or

weekly assessments had been conducted for the resident's injury. A review of the home's policy titled, "Skin and Wound Care Program", last revised June 27, 2016, indicated that, "upon identification of altered skin integrity (pressure ulcer, skin tear, wound burn, rash, abrasion, surgical wound, laceration, bruise etc.), [registered staff] initiate a baseline assessment using the Skin and Wound Assessment on PCC, and weekly until resolved".
SOC #270 confirmed that registered staff failed to complete initial and weekly skin and wound assessments for resident #140 with the use of an appropriate skin and wound assessment tool. (619) [s. 50. (2) (b)]

Additional Required Actions:

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

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that the resident was reassessed and the plan of

care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan had not been effective.

Resident #095 had a history of falls. The resident did not sustain any injury after the first identified number of falls. The resident had a history of behaviours related to their medical condition. In June 2017, the resident fell and sustained an injury. In July 2017, the resident fell and sustained another injury.
A review of a documents titled "Morse falls risk assessment", completed after each fall, indicated resident #095 was deemed a high risk for falls.
A review of initial post fall assessments, included several of the same falls prevention interventions in all of the assessments. No new interventions had been included in any of the assessments.
In an interview, the Physiotherapist (PT) indicated they first received a referral and assessed resident #095 after their injury sustained after the fall. Several recommendations were made and were included in the resident's written plan of care. The PT further indicated a device was implemented in July 2017, to prevent the
resident from injury related to an identified behaviour.
A review of a document titled "Restraint assessment and consent form", signed June 2017, indicated the resident was assessed and approved for identified devices after they sustained an injury, as a fall prevention strategy. An identified assessment form, signed September 2017, indicated the resident was assessed and approved for additional devices to be used as indicated for fall prevention.
In an interview, SOC #272 confirmed the home failed to ensure resident #095 was reassessed and the plan of care reviewed and revised when care set out in the plan, specific to falls prevention strategies after the resident falls had not been effective. [s. 6. (10) (b)] (591)

2. A review of the home's investigation notes indicated resident #085 had several falls in July 2017.
A review of the "Initial post fall assessment", dated July 2017, indicated the resident was found on the floor without injury. Falls prevention interventions were included. A referral was sent to the PT to assess the resident. The resident had progressed from being independent to requiring assistance for certain activities during the above mentioned time period.
A review of the "Initial post fall assessment", dated July 2017, indicated the resident was found on the floor. No injury was noted and interventions were the same as those listed in the previous assessment. Progress notes included identified strategies. The PT assessed the resident that day and made

recommendations.
A review of the "Initial post fall assessment", dated July 2017, for another fall that had occurred that month, indicated the nurse was informed that resident #085 was on the floor. The interventions included were the same as the previous assessment. The resident sustained an injury as a result of the fall.
A review of resident #085's written plan of care, completed August 2017, did not include falls prevention interventions and did not include the recommendations made by the PT when there was a change in the resident's condition. Interventions were included after the resident sustained an injury.
In an interview, SOC #272 indicated that the PT had assessed the resident and had made a specific recommendation prior to the fall and injury. The SOC confirmed the home failed to ensure the plan of care was reviewed and revised when resident #085'scare needs changed, and care set out in the plan had not been effective. [s. 6. (10) (b)] (591)

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

A tour of the home was completed on July 31, 2017, and all of the home's spa rooms were observed. When completing the observation of the shower room on an identified unit it was observed that the Alenti lift chair had no safety belt attached to the chair. Inspector #583 was unable to find a safely belt in the spa room. After requesting permission from the staff and resident, Inspector #583 entered the shower room on another unit. Resident #107 was observed sitting in the Alenti lift chair, and the safety belt was not applied.
In an interview with the staff they shared the belt was not applied. After requesting permission from the staff and resident, Inspector #583 entered the shower room on another unit. Resident #001 was observed sitting in the Alenti lift chair, and the safety belt was not applied. In an interview with the staff, they indicated that a safety belt was not required.
An interview was then completed with SOC #272 and it was confirmed that the home's expectation was that the safety belt was to be applied for all residents in the home when they were seated in the Alenti lift chair.
With the Director of Care (DOC) present an interview was completed by Inspector #583 with PCA #157. It was confirmed that there was no safety belt available in the shower room and that seven residents were showered in the Alenti lift chair without the application of the safety belt on a morning in July 2017. The "Alenti instructions for use" manual dated May 2015, directed that the safety belt was to be used at all times. A warning read "to avoid falling, make sure that the patient is positioned correctly and that the safety belt is being used, properly fastened and tightened". In an interview, the DOC confirmed that staff failed to use the Alenti lift chair in accordance with manufacturer's instructions. [s. 23.]

2. During a tour completed in the home on July 31, 2017, resident #130 was observed in their wheelchair. They had an identified device applied which was observed to be applied incorrectly. Registered staff #122 observed resident #130 with Inspector #583 and confirmed that the device was not applied correctly. The PT provided the manufacturer's instructions from "Body point", which provided direction for the correct use of the device, and requirements for its daily maintenance. The PT confirmed that resident #130's device was not applied as per the manufacturer's instructions. [s. 23.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76(7) of the Act based on the following: (1) Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76(7) of the Act.

A) A review of the home's training records related to abuse and neglect training was completed. The document titled, "Surge Learning - Abuse and Neglect",

indicated that for the 2016 calendar year 253 out of 272 staff, a total of 92 per cent (%), completed the mandatory training. An interview with the Program Support Nurse confirmed that this record encompassed the entirety of the prevention of abuse and neglect training for the home's staff. In an interview, the DOC confirmed that not all staff completed training in relation to the prevention of abuse and neglect.

B) The document titled, "Surge Learning - Falls Prevention and Management Program Education", indicated that for the 2016 calendar year 143 out of 155 direct care staff, a total of 92%, completed the mandatory training in relation to falls prevention and management. An interview with the Program Support Nurse confirmed that this record encompassed the entirety of the mandatory restraint training for the home's staff. In an interview, the DOC confirmed that not all staff completed training in relation to fall prevention and management.

C) A review of the home's training records titled, "Surge Learning - Skin and Wound Care Program", indicated that for the 2016 calendar year, 141 out of 157 direct care staff, a total of 96%, completed mandatory training in relation to skin and wound care. An interview with the Program Support Nurse confirmed that this record encompassed the entirety of the mandatory skin and wound care training for the home's staff. In an interview, the DOC confirmed that not all staff completed training in relation to skin and wound care.

D) A review of the home's training records related to the minimization of restraints was completed. The document titled, "Surge Learning - Minimization of Restraints", indicated that for the 2016 calendar year, 140 out of 153 direct care staff, a total of 91.5%, completed mandatory training in relation to restraints. An interview with the Program Support Nurse confirmed that this record encompassed the entirety of the mandatory restraint training for the home's staff. In an interview, the DOC confirmed that not all staff completed training in relation to the minimization of restraints.

E) A review of the home's training records related to responsive behaviour training was completed. The document titled, "Surge Learning - Responsive Behaviours", indicated for the 2016 calendar year 253 out of 272 direct care staff, a total of 92%, completed the mandatory training in relation to responsive behaviours management. An interview with Program Support Nurse confirmed that this record encompassed the entirety of the mandatory responsive behaviours management training for the home's staff.

The DOC confirmed that not all staff completed training in relation to responsive behaviours management.

The home failed to ensure staff who provided direct care to residents received annual training in all the areas required. [s. 221. (1) 1.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of the home's investigation notes indicated resident #083 sustained a fall in August 2017, which resulted in injuries. At the time of the incident, PCA #270 was providing care to the resident independently.
A review of resident #083's written plan of care, last reviewed July 2017, indicated the resident required total care for identified care by two staff, and total care by two to three staff for other identified care. The resident was identified as a high risk for falls due to multiple risk factors.
Interviews with the Physiotherapist, registered staff #116, and PCAs #220 and #227 indicated resident #083 required two staff to provide their care related to their medical condition.
SOC #272 confirmed that PCA #270 did not use a safe positioning technique which resulted in a fall and injury of resident #083. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to intervention were documented.

Resident #052 had a medical condition and identified responsive behaviours. In April 2016, resident #052 had an incident with resident #029 in which resident #029 was injured. A review of resident #052's written plan of care, last updated April 2016, indicated that the resident had a history of identified behaviours. A review of the home's policy titled, "Prevention and Management of Responsive Behaviour Program", last revised May 2014, stated, "The role of the Registered Nurse and Registered Practical Nurse (RPN), was to initiate the Direct Care Observation Study (DOS) on the electronic health record for seven (7) days, and, refer to the Behavioural Supports Ontario (BSO) consultant".
In an interview, registered staff #116 indicated that when a resident displayed a new including one that caused injury to a co-resident, registered staff were responsible for initiating a Direct Observational Study (DOS) monitoring protocol, and refer the resident to the Behavioural Support Ontario (BSO) consultant via electronic referral. A review of resident #052's progress notes and assessments did not indicate that the resident had DOS monitoring initiated or that a referral to BSO was completed.
Registered staff #116 confirmed in an interview that these requirements were not completed. In an interview, SOC #270 confirmed that registered staff did not initiate DOS monitoring or send a referral to the BSO for resident #052 after they displayed a new behaviour which resulted in an injury to a co-resident.
SOC #270 further confirmed that actions were not taken to respond to resident #052's behaviours and that no reassessments or interventions were implemented for this
resident. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to intervention are documented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that, all equipment and devices in the home were kept in good repair.

A review of resident #078's written plan of care identified that they were at high risk of falls related to their medical condition and their potential for injury. The falls care plan had multiple interventions, one of which included the use of a device when indicated.
In June 2017, resident #078 had an unwitnessed fall. An interview with registered staff #140, who had completed the post fall assessment, confirmed the device did not activate. They shared they did not report to maintenance that the device was not in good repair.
Inspector #583 observed resident #078 with the device in place. In an interview, PCA #156 was questioned as to how one would determine if the device was in good working order. The device did not activate during the demonstration. It was confirmed the device was not functioning.
In an interview with the maintenance staff, it was confirmed that a work request was not submitted for the above mentioned device in June 2017. They shared that identified devices were not part of the preventative maintenance program and that they relied on staff to submit a work request if they were not working. In an interview with registered staff #140 it was confirmed that resident #078's device was not in good repair at the time of their fall. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to ensure that, all equipment and devices in the home are kept in good repair, to be implemented voluntarily.

WN #11: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a physical device to restrain a resident under section 31 of the Act was document and, without limiting the generality of this requirement, the licensee failed to ensure that the following were documented (6) all assessment, reassessment, and monitoring, including the resident’s response.

Resident #095 had a history of a medical condition, and was considered a high risk for falls and had a history of falls with injury. In June 2017, the resident sustained an injury from a fall and was sent to the hospital for further assessment. On return to the home, registered staff #106 obtained a physician's order for an identified device, to be used for the resident as indicated.
A review of the resident's assessments indicated that registered staff #106 referred the resident to the Occupational Therapist (OT) for an assessment in June 2016. A review of the assessment indicated that the assessment for the device was completed in July 2017, indicating that the resident went a period of almost a month without a formal assessment for the use of the device.
In an interview, registered staff #116 indicated that registered staff were required to participate in and ensure that an assessment for identified devices was completed in conjunction with an assessment by the OT prior to the application of the devices, including the device used for resident #095, to ensure the resident's safety.
A review of the home's policy titled "Minimizing Restraint use and the use of Personal Assistance Services Devices (PASD) Program", last revised March 27, 2017, indicated that registered staff must "complete the Restraint/PASD assessment in the electronic health record prior to the application of the device".
In an interview, SOC #270 confirmed that resident #095 had the device applied for a period of 27 days without an assessment being completed. [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a physical device to restrain a resident under section 31 of the Act is document and ensure that the following are documented (6): all assessments, reassessments, and monitoring, including the resident's response, to be implemented voluntarily.

WN #12: 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. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee to keep a record, the licensee shall ensure that the record was kept in a readable and useable format that allowed a complete copy of the record to be readily produced.

In April 2016, resident #029 was injured in an incident with co-resident #052. A review of the "Risk Management report" completed in April 2016, described the resident's injury.
The progress notes indicated that an identified assessment was initiated in April 2016, and subsequent notes regarding the assessment were inconsistently documented in the progress notes across the following four shifts.
A review of the home's policy titled, "Falls Prevention and Management Program", index #LTC 05.08.12, last revised October 14, 2016, outlined directions complete the identified assessment, including monitoring, frequency of monitoring, and requirements for documentation.
Under the Ontario Regulations 79/10, the Falls Prevention and Management Program is a required program and that under s. 31 of the LTCHA, 2007, therefore the home has a duty to comply with the regulations including maintaining documentation in a useable format. During the course of the inspection the Inspector reviewed the identified assessment hard copy records to ensure the completion of the observation and determined that five out of seven records that were compiled due to various incidents the resident had since admission in 2013, did not include the date they were initiated on the documentation. Inspector #619 was unable to determine which record was related to which incident. In an interview, registered staff #116 indicated that staff must complete the identified assessment documentation fully, including the date the report was initiated as part of the resident's health record.
In an interview, SOC #270 confirmed that the resident's identified assessment report related to the injury they sustained in April 2016, as well as four other identified assessment reports from previous unrelated incidents, was incomplete as they did not include the date they were initiated. SOC #270 confirmed in an interview that the documentation was not consistent in the progress notes, and it was therefore impossible to discern which identified assessment record was related to which incident.
The SOC further confirmed that failure to include the date on the identified assessment reports rendered the documentation incomplete. [s. 8. (2)]

(A1)
The following Non-Compliance has been Revoked: WN #3

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 100. Undertaking to issue licence

Specifically failed to comply with the following:

s. 100. (3) An undertaking shall be in two parts, one to be described as "non-amendable components" and the other to be described as "amendable components". 2007, c. 8, s. 100 (3).

Issued on this 7 day of February 2018 (A1)

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

Original report signed by the inspector.