Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 15, 2019	2019_558123_0008	007789-19, 008092-19, 009096-19, 009178-19, 009868-19	Critical Incident System

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court BURLINGTON ON L7N 3N6

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

Millennium Trail Manor
6861 Oakwood Drive NIAGARA FALLS ON L2E 6S5

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 8, 9, 24, 28, 29, 30, 31, June 6, 11, 13 & 14, 17, 18, 19, July 23, 31 and August 2, 2019.

During the course of the inspection, the inspector: reviewed residents' records; reviewed the home's records including policies and procedures and observed residents, equipment and staff-resident interactions.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), registered staff, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, the Assistant Director of Care (ADOC), the Director of Care (DOC), the Assistant Director of Care (ADOC), the Nurse Practitioner (NP), and the Administrator.

The following critical incident inspections were included in this inspection:
007789-19 related to fall prevention;
008092-19 related to alleged abuse;
009096-19 related to alleged abuse;
009178-19 related to hospitalization and
009868-19 related to fall prevention.

The following complaint inspection was conducted concurrently with this inspection: 2019_558123_0007/001964-19.

Non-compliance LTCHA. s. 6. (5) was identified as a result of CI inspection #009096-19 and was issued in complaint inspection report # 2019_558123_0007/001964-19.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
7 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

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

Critical Incident (CI) report #2948-000003-19/ log #004534-19 submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in February 2019, which reported the alleged abuse involving resident #019 and resident #012 was reviewed. It was noted that on an identified date in February 2019, a Personal Support Worker (PSW) witnessed an altercation between resident #012 and resident #019. The PSW intervened and separated the residents. The registered staff assisted the PSW. The residents were assessed for injury by the registered staff. Resident #019 had an identified injury that resolved by the following morning. The residents' substitute decision-makers (SDMs) were notified of the incident. Staff continued to: observe the residents; monitor for potentially harmful interaction; assess medications; recent illnesses; advancement of disease and possible triggers.

The health record of resident #012 who had a history of responsive behaviours towards residents and staff was reviewed. It was noted that on an identified date in February 2019, residents #012 and #019 were involved in an altercation as indicated above in relation to CI report #2948-000003-19/ log #004534-19.
It was also noted that on an identified date in March 2019, resident #012 entered the room of resident #019 and was involved in an altercation with resident #019. PSW staff intervened and there was no injury to either resident.

Resident #012's plan of care was reviewed and it did not include a focus statement related to actual or potential responsive behaviours towards resident #019 or other residents nor did it include any information related to the resident's identified responsive behaviour as confirmed with the Director of Care (DOC) and the Assistant Director of Care (ADOC).

2. CI report #2948-000008-19/ log #009096-19, submitted to the MOHLTC on an identified date in May 2019, which reported the alleged unwitnessed abuse of resident #013 by resident #012 was reviewed. It was noted that on an identified date in May 2019, a registered staff heard resident #013. The staff arrived and residents #012 and #013 were separated. Reassurance was given to resident #013. Resident #013 had an identified injury and treatment was applied. The staff administered an identified medication to resident #012, who settled. The residents’ families were notified of the incident and a staff member monitored resident #012 following the incident. The home investigated the incident and planned to speak with resident #012’s family regarding a referral to an external service provider.

The health record of resident #013 including the care plan and progress notes was reviewed. The resident was noted to have a history of responsive behaviours. According to the progress notes, on an identified date in March 2019, resident #013 approached the registered staff and reported they had concerns about resident #012. Resident #012 was noted to be in the vicinity of resident #013's room. An altercation occurred between resident #013 and resident #012. Staff separated the residents.
The "Monthly Charting" of on identified date March 2019, indicated that resident #013 continued to have altercations with some of their co-residents and had identified behaviours.
The health record noted that on an identified date in March 2019, resident #013 was upset that resident #012 entered their room.

The "Monthly Charting" of an identified date in April 2019, indicated that resident #013 continued to demonstrate responsive behaviours.
Progress note documentation indicated that four days later, resident #013 was agitated and had an altercation with resident #012.
It was also noted that six days later, resident #013 had another altercation with resident #012.
The health record indicated that fifteen days later, staff observed resident #013 and resident #012 involved in an altercation. Resident #012 was redirected. Resident #013

was noted to demonstrate responsive behaviours.

On an identified date in May 2019, resident #013 was noted to have been involved in an altercation with resident #012 as noted in CI report #2948-000008-19/ log #009096-19 above.

Resident #012's plan of care dated May 2019, was reviewed and it did not include a focus statement related to actual or potential responsive behaviours with resident #013 and or other residents nor did it include any information related to the resident's identified responsive behaviour.

3. The health record of residents #011 was reviewed and according to progress note documentation on an identified date in February 2019, resident #012 and resident #011 had an altercation.
The progress note documentation indicated that on an identified date in March 2019, an altercation occurred between resident #012 and resident #011. Resident #012 was redirected to their room by the registered staff. There was no injury to either resident.
The "Monthly Charting" notes, on an identified date in March 2019, indicated resident #011 had identified responsive behaviours.
The progress notes of an identified date in April 2019, indicated that an altercation occurred between resident #011 and resident #012 and resident #011 was upset as a result. Resident #011 was given reassurance by staff.

The health record of resident #012 was reviewed including the progress notes. It was noted that on an identified date in April 2019, that resident #012 an altercation occurred between resident #011 and resident #012 and resident #011 was upset as a result.

Resident #012's plan of care dated May 2019, was reviewed and it did not include a focus statement related to actual or potential responsive behaviours with resident #011 and or other residents nor did it include any information related to the resident's specific responsive behaviour as confirmed by the DOC.

4. The health record of resident #012 was reviewed including: assessments; care plans dated February 2019 and May 2019, and progress notes. It was noted that resident #012 had a history of responsive behaviours towards residents and staff. Medication changes were noted between February and May 2019.

The progress note documentation included additional actual and or potential altercations with co-residents and in February 2019, had six documented altercations with co-residents. Medications were administered for the resident's responsive behaviours, on two occasions, which were documented as being effective.

B. In March 2019, resident #012 had two separate occasions where they had altercations with co-residents, which left the co-residents upset.
The March 2019, Monthly Charting noted resident #012 had a few altercations with other residents over the previous month. The resident required the administration of an identified medication for responsive behaviours several times over the previous 30 days. The resident demonstrated responsive behaviours towards staff.

C. In April 2019, resident #012 continued to demonstrate responsive behaviours and had ten documented altercations with co-residents, upsetting co-residents and requiring intervention by staff.
The April 2019, Monthly Charting indicated resident #012 wandered the home area; often went to the room of resident #013 and upset that resident. They were also had responsive behaviours towards co-residents.
The responsive behaviour meeting note, for resident #012, indicated the resident demonstrated physical responsive behaviours towards other residents and staff and a referral to an external service provider was in progress. Strategies previously implemented to manage the resident's responsive behaviours were noted to have been unsuccessful.

The May 2019, Monthly Charting indicated that resident #012 was involved in multiple incidents with other residents resulting in injuries and a referral to an external service provider was initiated.
The review of resident #012's plan of care did not include a focus statement related to the resident's potential or actual physical responsive behaviours towards other residents.

Resident #012's plan of care was not based on an assessment of the resident and the resident's needs and preferences related responsive behaviours and potential altercations between residents #011, #012, #013, #019 and other residents and their identified responsive behaviours as confirmed with the DOC and ADOC.

This area of non-compliance was issued as a result of CI inspection #009096-19. [S. 6.

(2)]

2. 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.

The health record of resident #012 was reviewed including: assessments; plans of care dated February 2019 and May 2019 and progress notes. It was noted that resident #012 had a history of responsive behaviours towards residents and staff.

The resident's plans of care indicated the resident would demonstrate responsive behaviours when staff assisted them with activities of daily living. Interventions included: Registered staff were to contact the resident's SDM if the resident demonstrated responsive behaviours when staff assisted them with activities of daily living. The staff were to also provide a specified intervention when the resident demonstrated the responsive behaviours while being assisted with activities of daily living. The plan of care also indicated the resident required an identified amount of staff assistance with activities of daily living.

Progress note documentation included a number of examples where the resident demonstrated responsive behaviours and staff did not follow the plan of care. The documentation did not indicate that the registered staff contacted the resident's SDM when the resident demonstrated responsive behaviours, although a few notes indicated that the SDM was notified following specific incidents.

Documentation did not include information that staff consistently, when the resident demonstrated responsive behaviours, left the resident and returned later to reattempt the provision of care.

Documentation reviewed indicated that care was provided, at times, when the resident demonstrated responsive behaviours, with greater than identified numbers of staff members present.

Progress note documentation indicated that on an identified date in March 2019, resident #012 demonstrated responsive behaviours and interventions were not recorded as being provided as set out in the plan of care.

In May 2019, resident #012 demonstrated responsive behaviours on 12 identified

occasions and interventions were not recorded as provided as identified in the plan of care.

In June 2019, resident #012 demonstrated responsive behaviours on three occasions and interventions were not recorded as provided as identified in the plan of care.

The DOC acknowledged care was not provided to resident #012 as per their plan of care related to responsive behaviours.

This area of non-compliance was issued in relation to log #009096-19. [s. 6. (7)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was protected from abuse by anyone.

i. CI report # 2948-000008-19 submitted to the MOHLTC on an identified date in May 2019, which reported an unwitnessed alleged abuse of a resident was reviewed. It was noted that on an identified date in May 2019, an altercation occurred between resident #012 and resident #013. The residents were separated, and reassurance was given to resident #013. Resident #013’s had an identified injury and treatment was applied. Resident #012 had a history of responsive behaviours. The staff administered an identified medication to resident #012 and it was effective. The residents’ families were notified of the incident and an extra staff member monitored resident #012. The home investigated the incident.

ii. The health record of resident #012, including assessments, care plan, Kardex and progress notes, was reviewed. It was noted that the resident had a history of responsive behaviours towards residents and staff members. Progress note documentation indicated that on an identified date in May 2019, registered staff witnessed an altercation between residents #012 and #018. The staff intervened but resident #018 sustained an area of altered skin integrity which was treated. Resident #012's SDM was notified of the incident.

The DOC confirmed the accuracy of the documented information and that resident #018 and resident #013 were abused by resident #012.

This area of non-compliance was identified as a result of critical incident log #009096-19. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone, and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home’s policy and procedure, Abuse-Prevention, Reporting and Elimination of Abuse and Neglect, #CA-O5-37-(1-13) was reviewed and included procedures and interventions when abuse/neglect are alleged, suspected or witnessed. It noted that "any person who suspects that abuse or neglect has occurred must report it to the registered staff who follows the same steps as if the abuse/neglect was witnessed" and any person who witnesses a resident being abused must report it at once to the registered staff and complete a written account of the incident which is submitted to the Administrator within 24-hours of the incident. The registered staff must contact the Administrator or designate immediately.

The health record of resident #012 including the progress notes was reviewed. It was noted that on an identified date in May 2019, resident #012 abused resident #018. The incident was reported to resident #012’s SDM.

The health record of resident #018 was reviewed including the progress notes and it indicated that on an identified date in May 2019, the registered staff witnessed an altercation between resident #012 and resident #018. The registered staff intervened, however resident #018 sustained an area of altered skin integrity. The area was treated and the incident was reported to the resident’s SDM.

The DOC reported that they followed-up and the registered staff did not report the abuse of resident #018 by resident #012 to the management of the home as per the home’s abuse policy and procedure.
The home's written policy to promote zero tolerance of abuse and neglect of residents was not complied with.

This area of non-compliance was issued as a result of CI inspection #009096-19. [s. 20. (1)]

2. CI reports #C2948-000009-19/ log #009178-19; 2948-000005-19/ log #007789-19 and 2948-000002-19/ log #004554-19 submitted to the MOHLTC that reported incidents involving resident #011 which caused injuries for which the resident was taken to hospital and which resulted in a significant change in the resident's health status were reviewed.

The health record of resident #011 were reviewed and it indicated that they had a history of responsive behaviours. It was noted that on an identified date in February 2019, was agitated, had new symptoms and requested additional interventions. The assessment by registered staff revealed the resident had identified injuries to identified body areas both of unknown origin. An identified medication was administered to the resident. The resident alleged abuse to staff.
In the morning, the resident developed further sign of injury, they complained alteration in comfort and reported they thought an identified body area was injured. Identified mediation was administered to the resident and staff continued to monitor the resident. The resident's family was notified and they questioned how the injury occurred. The residents signs of injury increased. The staff spoke to the resident they indicated they were not feeling well and asked to go to the hospital. The resident was transferred to the hospital where they were admitted with identified diagnoses. The resident returned to the home two weeks later.

The DOC confirmed the staff did not report resident #011's allegation of abuse to them and that the cause of the injuries were not witnessed and were unknown.

This area of non-compliance was identified as a result of CI inspections #007789-19 and 009178-19. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance there is a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied: alternatives to restraining the resident had been considered, and tried where appropriate, but would not have been, or had not been, effective in addressing the risk referred to in paragraph 1.

CI report #2948-000011-19/ log #009868-19 submitted to the MOHLTC on an identified date in May 2019, which reported an incident that caused injury to a resident for which they were taken to the hospital and which resulted in a significant change in the resident's health status was reviewed. It was noted that resident #017 had an unwitnessed fall. The following day, identified test results indicated the resident had an identified injury. They were transferred to the hospital and returned to the home on six days later.

The health record of resident #017 was reviewed including care plans, Kardex and progress notes. Progress notes documentation indicated that on identified dates in May

2019, the resident made attempts to complete an action that put them at risk for falling.

Three days later the resident completed an identified action and they fell. The resident was assessed and they were not injured. The resident's SDM was notified and requested that when the resident used an identified equipment a device was applied. The physician was contacted and ordered the device only when the resident was using the equipment.

The resident's May and June 2019, Restraint and or PASD with Restraining Flow sheet were reviewed. It was noted that the use of the device was initiated on an identified date in May 2019. It was to be used when the resident was using the identified equipment. There was no documentation found in the resident's health record which indicated that alternatives to restraining were considered, and tried, but were not effective in addressing the risk.

The home did not consider and try alternatives to restraining to reduce the risk of falling before initiating the use of the identified device by resident #017 on the identified date in May 2019, as confirmed by the DOC. [s. 31. (2) 2.]

2. The health record of resident #016, including the plan of care and was reviewed and it was noted that the resident required the use of an identified device when using an identified equipment. There was no documentation of alternatives to restraining that were considered and tried, but were not effective in addressing the risk.

The home was requested to provide documentation indicating the alternatives to restraining that were considered, and tried but were not effective in addressing the risk and the documentation was not provided. The DOC confirmed alternatives were not tried. [s. 31. (2) 2.]

3. The health record of resident #014 including Physician's Order Form and the March to June 2019, Restraint/PASD with Restraining Flow Sheets were reviewed and it was noted that the resident used an identified device when using an identified equipment to prevent them from attempting to ambulate. There was no documentation of alternatives to restraining that were considered, and tried but were ineffective, found in the resident's plan of care.

The home was requested to provide documentation indicating the alternatives to restraining that were considered, and tried but were not effective in addressing the risk and the documentation was not provided. The DOC confirmed alternatives were not tried.

This area on non-compliance was issued as a result of CI inspection #009868-19. [s. 31. (2) 2.]

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 the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

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

WN #5: 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 every resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

CI report #2948-000006-19/ log #008092-19 submitted to the MOHLTC on an identified date in April 2019, which reported the alleged abuse of a resident was reviewed. It indicated that on an identified date in April 2019, staff noted areas of altered skin integrity on identified body areas of resident #010. The staff did not know the cause of the injury. Care was provided, and the home implemented additional interventions. The resident's family was informed of the injuries and they requested an investigation.

The health record of resident #010 was reviewed including the progress notes. Progress note, late entry documentation, noted that on an identified date in April 2019, at an identified time, registered staff #109, indicated that on that date, resident #010 was aggressive and after they were provided care, the areas of altered skin integrity were noted on identified body areas. The documentation did not include any information indicating that the resident received immediate treatment or interventions to the areas of altered skin integrity. This late entry was the first documentation regarding the identified areas of altered skin integrity.

The home's investigation report was reviewed, and it was noted that on an identified date in April 2019, PSW #106 and #107 noted that resident #010 had areas of altered skin integrity, which were reported to registered staff #109, immediately following the provision of care.
Both PSWs denied knowing the cause of the resident's areas of altered skin integrity. Registered staff #109 observed the resident's areas of altered skin integrity, on the identified date in April 2019. However, in error they forgot to document their assessment or apply treatment or other interventions immediately.

PSWs #106 and #107 were interviewed and they reported information as noted in the home's investigation record. Registered staff #109 confirmed they did not document information about resident #010's areas of altered skin integrity, on the identified date in April 2019, and they did not apply treatment.

The home did not ensure that on April 14, 2019, resident #010's skin tears received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection as required. [s. 50. (2) (b) (ii)]

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

Critical Incident report #2948-000006-19, submitted to the MOHLTC on an identified date in April 2019, was reviewed. It was noted that resident #010 had areas of altered skin integrity on identified body areas.

The health record of resident #010 including assessments, progress notes and care plan was reviewed. It was noted that resident #010's had areas of altered skin integrity to identified body areas which were assessed by registered nursing staff on two identified dates in April 2019 and on four identified dates in May 2019. There were no weekly reassessments of the resident's areas of altered skin integrity found for an identified period between April and May 2019.

The DOC was requested to provide evidence of resident #010's weekly skin assessments for the period between the identified dates in April and May 2019, and it was not provided.

Resident #010's areas of altered skin integrity were not reassessed at least weekly by a member of the home's registered nursing staff as clinically indicated, as noted above and confirmed by the DOC.

This area of non-compliance was issued as a result of CI inspection #008092-19. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy under section 29 of the Act deals with, the duties and responsibilities of staff, including, who has the authority to apply a physical device to restrain a resident or release a resident from a physical device.

In accordance with LTCHA, 2007, s. 29 (a), every licensee of a long-term care home, shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining is done in accordance with this Act and the regulations.

The home's policy and procedure Restraints, #CN-R-05-(1-11), dated February 2016, was reviewed and it did not indicate what staff had the authority to apply or release a physical device. The document referred to "staff" and "appropriate staff" but it did not specify staff of which discipline had the authority to apply a physical device to restrain a resident or to release a resident as confirmed by record review and the Administrator.

This area of non-compliance was issued as a result of CI inspection #009868-19. [s. 109. (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy under section 29 of the Act deals with, duties and responsibilities of staff, including, who has the authority to apply a physical device to restrain a resident or release a resident from a physical device, to be implemented voluntarily.

WN #7: 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).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

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

1. The health record of resident #017, including physician's order of an identified date in May 2019 and the May and June 2019, Restraint and or Personal Assistance Services Device (PASD) with Restraining Flow Sheets were reviewed. The physician's order indicated the resident was to use an identified device as a restraint. The May and June 2019, Restraint and or PASD with Restraining Flow Sheets noted that the resident's use of the device was initiated on an identified date in May 2019. The resident was to use the device when using an identified equipment. The records did not include documentation of reassessments by registered staff every eight hours on identified dates in May and June 2019.

The Restraint and or PASD with Restraining Flow Sheet documentation did not include all assessments, reassessments and monitoring of resident #017's responses to the device as noted above as confirmed by record review and the DOC.

2. The health record of resident #016 including the care plan and the Restraint/PASD

with Restraining Flow Sheets dated March to June 2019, were reviewed and it was noted they used an identified device when using identified equipment as requested by their SDM.
The Kardex indicated the resident used the identified device as a restraint when using the identified equipment. The staff were to check, re-position, undo, reapply the restraint and monitor the resident for signs of skin breakdown.
The records did not include documentation of reassessments by registered staff every eight hours on identified dates in May and June 2019.

The Restraint and or PASD with Restraining Flow Sheet documentation did not include all assessments, reassessments and monitoring of resident #016's responses to the device as noted above and was confirmed by record review and the DOC.

3. The health record of resident #014 including the Physician's Order From and the Restraint/PASD with Restraining Flow Sheets, dated March to June 2019, were reviewed and it was noted that the resident used an identified device when using identified equipment. The Restraint/PASD with Restraining Flow Sheets did not include all assessments, reassessments and monitoring, including the resident's response on identified dates in May and June 2019.

The Restraint and or PASD with Restraining Flow Sheet documentation did not include all assessments, reassessments and monitoring of resident #014's responses to the device as noted above and was confirmed by record review and the DOC.

This area of non-compliance was issued as a result of CI inspection #009868-19. [s. 110. (7) 6.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the following was documented: every release of the device and all repositioning.

1. The health record of resident #017, including physician's order of an identified date in May 2019 and the May and June 2019, Restraint and or PASD with Restraining Flow Sheets were reviewed. The physician's order indicated the resident was to use an

identified device when using identified equipment. The May and June 2019, Restraint and or PASD with Restraining Flow Sheets noted that the resident's use of the device was initiated on an identified date in May 2019. The resident was to use the device when using identified equipment.
Resident #017's May and June 2019, Restraint and or PASD with Restraining Flow Sheets did not include documentation of every release of the device and their repositioning and had multiple blank spaces during that time period including identified dates in May and June 2019.

The restraint documentation did not include every release of resident #017's device and repositioning of the resident as noted above and was confirmed by record review and the DOC.

2. The health record of resident #016 including the care plan and the Restraint/PASD with Restraining Flow Sheets dated March to June 2019, were reviewed and it was noted they used an identified device to prevent falls.
The documentation did not include every release of the device and all repositioning on identified dates in May and June 2019.

The documentation did not include every release of the device and all repositioning as noted above and was verified by record review and the DOC.

3. The health record of resident #014 including Physician's Order Form and the Restraint/PASD with Restraining Flow Sheets, dated March to June 2019, were reviewed and it was noted that the resident used an identified device when using an identified equipment. The documentation did not include every release of the device and repositioning of the resident on identified dates in June 2019.

The documentation did not include every release and repositioning of the resident as noted above and was confirmed by record review and the DOC.

This area of non-compliance was issued as a result of CI inspection #009868-19. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every 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: All assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning, to be implemented voluntarily.

Issued on this 19th day of September, 2019

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

Original report signed by the inspector.