Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2018	2018_575214_0011	013928-18	Resident Quality Inspection

Licensee/Titulaire de permis

Benevolent Society "Heidehof" for the Care of the Aged
600 Lake Street St. Catharines ON L2N 4J4

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

Heidehof Long Term Care Home
600 Lake Street St. Catharines ON L2N 4J4

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

CATHY FEDIASH (214), ROSEANNE WESTERN (508), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 25, 26, 27, 28, July 3, 4, 5, 6, 9, 11, 12, 13, 16, 2018.

The following inspections were conducted concurrently with this Resident Quality Inspection (RQI):

Critical Incident System(CIS) intake #002085-18- related to transferring and position techniques.

Complaint Inquiry intake #004515-18- related to Bill of Rights; Infection Prevention and Control; Accommodation-Housekeeping; Continence Care and Bowel Management; Safe and Secure Home.

Complaint Inquiry intake #000318-18- related to Prevention of Abuse and Neglect; Medical Services and Snack and Dining Services.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Dietary Manager; Registered Dietitian (RD); Life Enrichment Manager; Resident Assessment Instrument (RAI) Coordinator; Physician;Registered Nurses (RNs); Registered Practical Nurses (RPNs); Personal Support Workers (PSWs); residents and family members.

During the course of the inspection, the Inspector(s) toured the home; reviewed relevant documents including but not limited to, clinical records, policies and procedures, and training records and observed the provision of care and administration of medications.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

s. 6. (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. (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 there was a written plan of care for each resident that set out the planned care for the resident.

Resident #003 was observed on an identified date, with a specified device in place, while using their mobility device.

An interview with registered staff #147 and PSW staff #215 on an identified date, indicated that the device was used to promote specified activities of daily living (ADL's).

An interview with the ADOC on an identified date, confirmed that the device was used for

resident #003 to promote specified ADL's.

A review of the current electronic document that the home refers to as the care plan and dated with an identified date, indicated under interventions for a specified ADL, with a revised, identified date, that resident #003 used the device while using their mobility device and would often remove the identified device. A review of the resident's written plan of care including the care plan document, had not contained any information regarding the needs or preferences of the resident's specified ADL and had not contained information in relation to the use of the device to promote the residents identified ADL.

An interview with the ADOC on an identified date, confirmed that the written plan of care in place for resident #003, had not set out the planned care in relation to the their identified ADL needs and preferences. [s. 6. (1) (a)]

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.

During a tour of the facility on an identified date, it was observed on an identified unit in the home, that a resident call bell had been ringing for an approximate determined length of time. Long Term Care Homes (LTCH) Inspector#508 identified that the call bell was coming from a specified room as an indicator light was also flashing above the resident's room door.

LTCH Inspector #508 went into the resident's room and observed a resident to have called out for assistance. The resident was unattended. PSW staff #223 was at the other end of the hallway walking towards the LTCH Inspector, entered the resident's room and informed the resident that they would be back to assist the resident with a specified task. The PSW staff then came back and assisted the resident.

During interview with registered staff #146 on an identified date, the registered staff indicated that at the time of this observation, PSW staff were assisting other residents; however, there were only two PSW staff on the unit as two PSWs were on break and they were working short that shift as one PSW had called in sick.

A review of the resident's clinical records indicated that the resident was at risk for falling and required one to two staff to assist with a specified ADL and required constant supervision for the identified ADL; however, the resident was observed to be left

It was confirmed during observation and during record review of the resident's clinical record that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. 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 the resident's care needs change or care set out in the plan was no longer necessary.

Resident #002 was observed on an identified date, to be using a specified device while using their mobility device.

A review of the electronic document that the home refers to as the care plan, indicated under a specified ADL, that interventions in place and dated with an identified initiated date, indicated that the resident had a specified device on their mobility device and that the resident was able to open and close unassisted.

Review of the resident's clinical record indicated specified diagnoses for the resident.

Review of the most recent Resident Assessment Protocol (RAP) for ADL Functional Rehabilitation Potential and dated with an identified date, indicated that the resident required a specified amount of assistance with many of their ADL's.

During an interview with resident #002 and PSW staff #156 on an identified date, PSW staff #156 asked the resident if they were able to undo and then close their specified device. The resident was able to undo the device unassisted; however, was unable to do the device back up and indicated an identified reason.

During an interview with the ADOC on an identified date, they indicated that they had not been aware that the resident was no longer able to fully manage their device and confirmed that resident #002's plan of care had not been updated when their care needs changed. [s. 6. (10) (b)]

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

A review of the resident's clinical record indicated that the resident was identified as a specified risk for falls and had a specified quantity of falls, over an identified period of approximately nine months. Falls that occurred on 10 identified dates, had been unwitnessed, where staff had identified the specified reasons for the falls.

Review of the resident's current plan of care indicated that there were no changes to the resident's identified ADL plan or the falls prevention plan until an identified date, when a specified device had been implemented. The resident had an identified amount of additional falls after implementing the specified device. The resident sustained an identified injury after an unwitnessed fall on an identified date. Discussions held with the resident's Substitute Decision Maker (SDM) and the ADOC regarding the use of another specified device did not take place for approximately 11 weeks since the implementation of the previous intervention.

It was confirmed during interview on an identified date, with the ADOC and during record review that interventions in the resident's plan of care had not been effective and that different approaches had not been considered until after the resident had an identified quantity of falls. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that that when a resident is reassessed and the plan of care reviewed and revised that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.

A) Resident #002 was observed on an identified date, to be using a specified device while using their identified mobility device. The resident was able to undo the device when asked.

A review of the electronic document that the home refers to as the care plan, indicated under specified interventions and dated with an initiated identified date, that the resident had a specified device on their mobility device and that the resident was able to open and close unassisted.

A review of resident #002's plan of care, in relation to an interdisciplinary assessment for the reasons for use of the device, indicated that no assessment could be found.

The home kept a binder on each floor related to the use of specified devices. A review of the binder on the resident's floor, on an identified date, indicated that the resident's name was under a list that had not classified their device and indicated that the device was worn by choice.

During an interview with PSW staff # 156 on an identified date, they identified a specified reason for the resident using the device.

An interview with the ADOC on an identified date, indicated that an interdisciplinary assessment had not been completed to assess the reasons for the use of the device for resident #002.

B) Resident #003 was observed on an identified date, with a specified device in place, while using their mobility device.

On an identified date, LTCH Inspector #508 observed resident #003, to remove the device from their mobility device.

A review of the current electronic document that the home refers to as the care plan and dated with a specified date, indicated under specified interventions with a revised identified date, that resident #003 used a specified device while using their mobility

device and would often remove the device.

A review of resident #003's plan of care, in relation to an interdisciplinary assessment for the reasons for use of the device, indicated that no assessments could be found.

An interview with registered staff #147 and PSW staff #215 on an identified date, indicated specified reasons that the device was used for resident #003.

An interview with the ADOC on an identified date, indicated that the device was used for resident #003 for a specified reason and that an interdisciplinary assessment had not been completed to assess the reasons for the use of the device for resident #003.

The plan of care for resident #002 and #003, had not been based on an interdisciplinary assessment with respect to safety risks. [s. 26. (3) 19.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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. In accordance with O. Reg. 79/10, 30(1), The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure that a written record related to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

At the time of this inspection the Administrator could not provide written records of their annual review of their required programs. During interview with the Administrator on an identified date, the Administrator indicated that the Director of Care and the Administrator did conduct an annual review of their required programs in 2017 and made changes to the skin and wound and Falls Prevention and Management program; however, had not kept a written record to each evaluation.

It was confirmed by the Administrator on an identified date, that the programs had been reviewed annually; however a written record related to each evaluation had not been completed. [s. 30. (1) 4.]

2. 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.

During stage one interview and census reviews, it was indicated that resident #008 had an alteration to their skin integrity to an identified area.

A review of the resident's clinical records indicated that a progress note dated on an identified date and time, indicated that the resident began to complain of pain to a specified area on their body and that an assessment identified an alteration to their skin integrity to this area.

Review of a specified assessment in Point Click Care and dated with an identified date, indicated that the area of skin alteration was assessed as a specified type of skin alteration. A review of a specified assessment, dated seven days later, indicated that the alteration to the residents skin integrity was classified as a different type of skin alteration.

A review of the electronic Treatment Administration Record (e-TAR) for a specified period of time, indicated that the resident was to have a specified treatment applied. A review of the e-TAR indicated that no documentation was recorded on an identified date, for this treatment. An interview with registered staff #148 on a specified date, indicated that they

had applied the treatment on the identified date; however, forgot to document this action on the e-TAR. [s. 30. (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 to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation; the names of the persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #4: 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 a Critical Incident System (CIS), with a specified number, indicated that on an identified date, resident #015 was using in their mobility device in the hallway, following assistance with a specified ADL. PSW staff #166 had seen the resident waiting in the hallway and started to transport the resident to their room. The CIS indicated that PSW staff #221, had seen PSW #166 assisting the resident down the hallway and shouted to them to stop so that they could apply an identified device on the resident's mobility device. PSW staff #166 stopped and PSW staff #221 applied the specified device. PSW staff #166 indicated that the resident yelled out when they stopped assisting the resident. The CIS indicated that PSW #166 had not immediately reported this to the registered staff as they indicated there was no known trauma at the time. Following lunch, the resident verbalized pain to an identified area. The CIS indicated that at this time, the

resident had the specified device in place; and no injuries were noted. The CIS indicated that the resident was assisted with a specified ADL at least three more times into the evening as per usual and that the resident verbalized in the evening on an identified date, that they had pain to an identified area on their body from an identified incident, earlier in the day. The CIS indicated that at a specified time, the same day, the resident had no verbalized complaints of pain and no identified injury. The following morning, the resident verbalized pain to a specified area when staff were assisting with an identified ADL task. The CIS indicated that registered staff assessed the identified area and noted slight swelling. The resident's physician was notified and a specified diagnostic test was ordered. The CIS indicated that the diagnostic test was completed on an identified date and a verbal report was received that the resident had an identified area of injury on their body. The CIS indicated that the physician was notified and resident was transferred to hospital for assessment on an identified date and returned back to the home the following day with a specified treatment in place.

A review of the resident's written care plan for interventions in place for a specified ADL and dated with an identified initiated date, indicated that staff were to apply a specified device to the residents identified mobility device, when the resident was using their mobility device.

During an interview with the Administrator on an identified date, they indicated that the home did investigate the incident and that disciplinary action had been taken towards PSW staff #166.

During an interview with PSW staff #166 on an identified date, they indicated that the events identified in the CIS were accurate; that the resident used a specified device while using their identified mobility device and that the specified device was not in place when they were assisted by PSW #166 on an identified date.

During an interview with the ADOC on an identified date, they indicated that the staff had not used safe techniques when assisting resident #015.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #0002085-18, conducted concurrently during the Resident Quality Inspection (RQI). [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and that was secured and locked.

A review of resident #008's progress notes indicated that on an identified date and time, resident #008 told PSW staff #198 that there had been a specified drug left behind the nurse's station for them. The progress note indicated that the resident went behind the nursing station and grabbed the specified drug from a drawer at the nursing desk and that PSW #198 reported this to registered staff #152 after this occurred. The progress note indicated that resident #008 told registered staff #152 that they took a quantity of two of the specified drug. The progress note indicated that registered staff #152 spoke

to registered staff #138 about the situation. The progress note indicated that the resident had not been at their maximum daily dose for the specified drug and that the resident had received the specified drug when needed (prn), when requested.

During an interview with PSW #198 on an identified date, they indicated that the resident came through the half door and into the nursing station and indicated to the PSW that the two pills on the counter, in the medication cup, were their specified drug and picked up the medication cup and took them.

During an interview with registered staff #152 on an identified date, they indicated that PSW #198 had informed them that the resident had gone behind the nursing station desk and took the specified drug that was in a medication cup in the desk drawer. The RPN indicated that they were sure about the specific type of drug as this had occurred before and that night staff leave this type of drug specifically in this location and that the specified drug was a prn drug. The RPN indicated that this had been reported to the DOC and that they had reported this incident to registered staff #138, at the time they were made aware.

During an interview with registered staff #138 on an identified date, they indicated that they had been made aware of the incident by registered staff #152. Registered staff #138 indicated that they were not aware as to how resident #008 had been aware that the specified drug was in the desk drawer.

During an interview with the Administrator and the ADOC on an identified date, it was confirmed that drugs had not been stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies and that was secured and locked. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and that is secured and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

During a tour of the facility on an identified date, it was identified in a specified shower and tub suite that two pairs of nail clippers were on a cart next to the tub. No labels were on the nail clippers to identify who they belonged to. On an identified floor, in the shower and tub suite it was observed that a cabinet containing residents personal care items such as nail clippers, nail clippings were noted on the inside of three of the drawers. This was also identified in another identified shower and tub suite when the drawers were opened. In a specified shower and tub suite, it was observed that five combs placed on the sink in the bathroom area, had no labels. It was also identified that there was a basket in this area next to the sink containing a stick deodorant and several combs with no labels on any of these items.

During interview with the DOC on an identified date, it was confirmed that the personal care items of the residents should be labelled to identify who they belonged to for prevention of infection. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: 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 required the licensee of a long-term care home to have, instituted or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s.50(2)(b)(iii) the licensee was required to ensure that a registered dietitian (RD) assessed a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

The home's policy and procedure for the Skin and Wound Care Program, N-11-01 with an identified revision date, stated that registered staff were to make referrals to interdisciplinary team members as required (e.g. registered dietician, physiotherapist). It was not clear in the policy that all residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds were to be assessed by the registered dietician.

During an interview with the Administrator on an identified date, it was confirmed that this was the home's current Skin and Wound Care policy and that it was not in compliance with and implemented in accordance with all applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O. Reg. 79/10, the licensee was required to ensure that the nutrition care and hydration program included (e) a weight monitoring system to measure

and record with respect to each resident.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have instituted or otherwise put in place any policy, the policy was complied with.

Specifically, staff did not comply with the licensee's Weighing of Residents policy, revised on an identified date.

The home's Weighing of Residents policy states that residents are weighed at the beginning of each month unless otherwise indicated. If a residents weight has changed by 2 kilograms (kg) either in gain or loss, the dietician is notified by nursing staff. The resident is again weighed one week later, and the dietician is notified with the results.

A) A review of the resident's clinical record for resident #007 indicated that the resident had their monthly weight obtained on an identified date, with an identified recorded amount. The following month, the resident was weighed with a recorded weight that required the resident to be re-weighed one week later. The resident had not been weighed one week later.

B) A review of the resident's clinical record for resident #003 indicated that the resident had their monthly weight obtained on an identified date, with an identified recorded amount. The following month, the resident was weighed with a recorded weight that required the resident to be re-weighed one week later. The resident had not been weighed one week later.

C) A review of the resident's clinical record for resident #010 indicated that the resident had their monthly weight obtained on an identified date, with an identified recorded amount. The following month, the resident was weighed with a recorded weight that required the resident to be re-weighed one week later. The resident had not been weighed one week later.

It was confirmed during an interview on an identified date, with staff #163 that these residents should have had another weight obtained one week after it was identified that there was a variance of 2 kg or greater either in gain or loss. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident had been assessed and, when required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #011 had been identified with a specified risk for falls according to their most recent falls risk assessment dated on a specified date.

A review of the resident's clinical record indicated that the resident had three falls in a specified period of time. On an identified date, the resident was assisted with an identified ADL by staff. When the staff returned to the resident's room, they discovered the resident had fallen with identified injuries to specified areas on their body.

The registered staff assessed the resident and provided identified treatment. The resident was transferred to hospital for further assessment. It was confirmed in hospital that the resident sustained an identified injury from their fall.

Five days later, resident #011 sustained two falls that resulted in injuries to identified areas on their body. The resident was treated at the home for these injuries.

Further review of the resident's clinical record indicated that a post fall assessment had not been conducted using a clinically appropriate assessment instrument, that was specifically designed for falls, for any of these falls which resulted in injury to the resident.

This information was reviewed with the ADOC and was confirmed on an identified date, that the post fall assessment using a clinically appropriate assessment instrument was required and that it had not been completed. [s. 49. (2)]

WN #9: 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 the 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.

Resident #004 was admitted to the home on an identified date. Nine days later, it was identified that the resident had developed an identified alteration to their skin integrity to a specified area on their body. A specified treatment order was implemented the following day.

During review of the resident's clinical record it was identified that weekly wound assessments were being completed until . According to the Electronic Treatment Administration Record (e-TAR) for a specified period of time, the resident continued to receive treatment for their altered skin integrity, as prescribed.

On an identified date, registered staff #136 confirmed that the resident still had an alteration in their skin integrity and although the alteration had closed it was not healed.

It was confirmed through documentation review and during interview with registered staff #136 that the resident still exhibited altered skin integrity and that the resident had not

received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment for an identified period of approximately three weeks. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who is a member of the staff of the home.

During stage one interview and census reviews, it was indicated that resident #008 had an alteration to their skin integrity to an identified area on their body.

A review of the resident's clinical records indicated that a progress note dated on an identified date and time, indicated that the resident began to complain of pain to a specified area on their body and that an assessment identified an alteration to their skin integrity to this area.

Review of a specified assessment in Point Click Care and dated with an identified date, indicated that the area of skin alteration was assessed as a specified type of skin alteration. A review of a specified assessment, dated seven days later, indicated that the alteration to the residents skin integrity was classified as a different type of skin alteration.

The LTCH Inspector observed the resident's alteration to their skin integrity on an identified date, with registered staff #144. On observation and as indicated by registered staff #144, the altered skin integrity, had healed.

A review of the resident's clinical records indicated that the most recent nutritional assessments were a Nutrition Assessment dated with an identified date and a Nutrition Risk Assessment dated the following day. No further nutritional assessments were identified that resident #008 had been assessed by a Registered Dietitian (RD) who was a member of the staff of the home, in relation to their alteration in their skin integrity.

An interview with the RD and Dietary Manager on an identified date, indicated that nursing staff complete a paper referral to the RD and give the referral to the dietary aid who in turn, brings the referral to the Dietary Manager. The ADOC confirmed that this is the practice in the home and that registered staff document the completion of the referral in the progress notes. A review of the resident's progress notes for an identified period of five weeks, indicated that no documentation was present that a referral had been

completed.

The RD and Dietary Manger confirmed that resident #008 had not been assessed by the RD as they had not received a referral from nursing staff to notify them of the resident's altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that a resident exhibiting 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.

During stage one interview and census reviews, it was indicated that resident #008 had an alteration to their skin integrity to an identified area on their body.

A review of the resident's clinical records indicated that a progress note dated on an identified date and time, indicated that the resident began to complain of pain to a specified area on their body and that an assessment identified an alteration to their skin integrity to this area

Review of a specified assessment in Point Click Care and dated with an identified date, indicated that the area of skin alteration was assessed as a specified type of skin alteration. A review of a specified assessment, dated seven days later, indicated that the alteration to the residents skin integrity was classified as a different type of skin alteration.

A review of the e-TAR for an identified period of time, indicated that the resident was to have a weekly wound assessment for their identified alteration to their skin integrity, every six days. A review of the e-TAR indicated that documentation of initials was present for the wound being assessed on two identified dates, by registered staff #150. A review of weekly wound assessments in PCC and progress notes for a period of six days, with registered staff #150 on an identified date, indicated that the staff member had documented on the e-TAR that the weekly wound assessments had been completed on these dates; however, they had not completed the weekly wound assessments as they forgot to go back into the PCC system to complete them. [s. 50. (2) (b) (iv)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of a Medication Incident Report indicated that on an identified date and time, it was identified that a specified drug had not been removed from resident #016, as prescribed.

An interview with registered staff #149 on an identified date, indicated that the staff member had been supervising a nursing consolidation student and had asked the student to remove the drug, on the identified date. The registered staff indicated that they were made aware on the following day by registered staff #152, that the drug had not been removed, as prescribed, but removed by registered staff #152, the following morning.

During an interview with the ADOC on an identified date, it was confirmed that drugs had not been administered to resident #016 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

A review of resident #008's progress notes indicated that on an identified date and time,

resident #008 told PSW staff #198 that there had been a specified drug left behind the nurse's station for them. The progress note indicated that the resident went behind the nursing station and grabbed the specified drug from a drawer at the nursing desk and that PSW #198 reported this to registered staff #152 after this occurred. The progress note indicated that resident #008 told registered staff #152 that they took a quantity of two of the specified drug. The progress note indicated that registered staff #152 spoke to registered staff #138 about the situation. The progress note indicated that the resident had not been at their maximum daily dose for the specified drug and that the resident had received the specified drug when needed (prn), when requested.

During an interview with PSW #198 on an identified date, they indicated that the resident came through the half door and into the nursing station and indicated to the PSW that the two pills on the counter, in the medication cup, were their specified drug and picked up the medication cup and took them.

During an interview with registered staff #152 on an identified date, they indicated that PSW #198 had informed them that the resident had gone behind the nursing station desk and took the specified drug that was in a medication cup in the desk drawer. The RPN indicated that they were sure about the specific type of drug as this had occurred before and that night staff leave this type of drug specifically in this location and that the specified drug was a prn drug. The RPN indicated that this had been reported to the DOC and that they had reported this incident to registered staff #138, at the time they were made aware.

During an interview with registered staff #138 on an identified date, they indicated that they had been made aware of the incident by registered staff #152. Registered staff #138 indicated that they were not aware as to how resident #008 had been aware that the specified drug was in the desk drawer. Registered staff #138 indicated that together with registered staff #152, they reviewed resident #008's medication orders and confirmed that the resident was prescribed the identified drug and that the resident had not reached their daily allowed quantity and that documentation was completed on the electronic Medication Administration Record (e-MAR) to identify that the resident had taken the prescription.

A review of the resident's e-MAR for an identified date, indicated that the resident was prescribed the identified drug; however, the order had not identified that the resident was able to self-administer this medication.

During an interview with the ADOC on an identified date, they confirmed that resident #008 had not been approved by their physician, to self-administer this medication. [s. 131. (5)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of a Medication Incident Report indicated that on an identified date and time, it was identified that a specified drug had not been removed from resident #016, as prescribed.

An interview with registered staff #149 on an identified date, indicated that the staff member had been supervising a nursing consolidation student and had asked the student to remove the drug, on the identified date. The registered staff indicated that they were made aware on the following day by registered staff #152, that the drug had not been removed, as prescribed, but removed by registered staff #152, the following morning.

A review of the Report of Medication Error contained an area for the writer to document notification of the medication incident to the resident and or their family. No documentation had been recorded in this area on the report. A review of the resident's progress notes for an identified period of three, consecutive dates, had not indicated any documentation that the resident and or their family had been notified.

An interview with the DOC on an identified date, indicated that it was the responsibility of the registered staff who identified the medication error, to notify the resident and or their substitute decision maker (SDM).

An interview with the DOC and registered staff #149 and #152 on an identified date, indicated that the above medication incident had not been reported to resident #016 or their SDM. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview with the DOC, it was indicated that the home last reviewed medication incidents and adverse drug reactions for an identified three month period in time. The DOC indicated that medication incidents are reviewed quarterly at the Professional Advisory Committee (PAC) meetings.

A review of medication incidents and adverse drug reactions for this time period indicated that one medication incident had occurred on an identified date.

A review of the PAC minutes with an identified date, indicated that the medication incident identified on a specified date, had been reviewed and no harm was noted to the resident. The minutes indicated that action to prevent error of same nature had been discussed; however, the quarterly review had not indicated any information regarding the details of the medication incident, including the type of medication incident; any contributing factors; interventions put into place at the time of the incident and whether or not the interventions put into place had been effective in reducing and preventing medication incidents of a similar nature.

During an interview with the ADOC on an identified date, it was confirmed that the home did meet to conduct a quarterly review of all medication incidents in the home for the identified period in time; however, the review had not contained information specific to reducing and preventing the medication incident and any adverse reactions. [s. 135. (3)]

Issued on this 7th day of September, 2018

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

Original report signed by the inspector.