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

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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
Oct 23, 2018	2018_687607_0007	031502-16	Complaint

Licensee/Titulaire de permis

The Mennonite Home Association of York County
123 Weldon Road Stouffville ON L4A 0G8

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

Parkview Home Long-Term Care
123 Weldon Road Stouffville ON L4A 0G8

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 4, 5, 6, 9, 10, 11, 19 and 20, 2018

The following log was reviewed and inspected during this Complaint inspection:

1) Log # 031502-16- A complaint regarding care areas, related to continence care, hospitalizations, falls, bathing, nutrition and hydration and staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Resource Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), a Dietary Aide (DA), a Restorative Aide (RA), the Scheduling Clerk, Care Coordinator/Administrative Assistant (CCAA), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector reviewed resident's clinical health records, observed staff to residents interactions, reviewed the homes investigation notes and reviewed home specific policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Resident Charges
Sufficient Staffing

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

7 WN(s)
5 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care, so that the different aspects of care are integrated, consistent with and complement each other.

The Ministry of Health and Long-term Care (MOHLTC) received a complaint Log #031502-16 on an identified date, related to nutrition involving resident #001.

A review of resident #001's plan of care identified the resident to be at an identified nutritional risk, as they were newly admitted to the home and had an identified diagnosis.

A review of an external agency request form with an identified date, indicated a referral was made for resident #001 to be assessed by a Speech and Language Pathologist (SLP), as the resident had an identified nutritional risk. Further review of the external agency referral indicated the resident was on an identified diet while in hospital; the family member noted that the resident had some difficulty with eating.

A review of the progress notes with an identified date, indicated that resident #001 was assessed by the SLP during an identified meal. The SLP recommended that the home continue to provide an identified food and fluid consistency. The service plan was for the SLP to follow-up in one week to ensure the resident tolerated the recommended fluid consistency well.

Further review of the progress notes written by the SLP 13 days after the initial assessment, indicated the SLP returned to the home to assess resident #001. The SLP indicated the resident remains at an identified nutritional risk and recommended that the resident continue with the most recent recommendations and would follow up in two to three weeks.

A review of the progress notes documented by the RD two days after the SLP second visit, indicated that the RD spoke with resident #001’s family member, who indicated that the resident was noted to have an identified issue when fed a specific fluid consistency, and is on an identified fluid consistency recently, and this was the reason the SLP assessment was requested. The family member indicated to the RD that they had implemented their own interventions related to resident #001’s fluids consistency when feeding the resident. The RD also documented speaking to the family member related to the risk of providing this fluid consistency to the resident, and the family member had indicated to the RD of being aware of the risk.

During an interview with RPN #104 on an identified date and time, indicated to inspector #607 that resident #001 was at an identified risk related to nutrition, was on an identified fluid consistency, and was also assessed by the SLP. The RPN indicated that if the SLP made recommendations, the RD is responsible for implementing the changes recommended.

During an interview with the RD on an identified date and time, indicated to the inspector that when resident #001 was assessed initially by the SLP, the home did not have the recommended fluid consistency available to be provided to the resident, and therefore the SLP recommendation was not provided to the resident until the RD returned from vacation, 16 days after the initial assessment.

During an interview with the Director of Care (DOC) on an identified date, indicated to the inspector that when a resident was assessed by the SLP and the SLP made recommendations, the licensee's expectation is that the staff would follow-up with an on call physician to approve the recommendations, if the RD was on vacation.

The licensee failed to ensure that when resident #001 was assessed by the SLP on an identified date, and the SLP made recommendations related to the resident's identified nutritional risk and fluid consistency, the recommendations by the SLP was not provided to the resident by a RD or a physician, until 16 days later. [s. 6. (4) (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 ensuring that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care, so that the different aspects of care are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Under O. Reg. 79/10, s.68 (1) (2) (a), Every licensee of a long term care home shall ensure that the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

A review of the Parkview Home Hydration policy #FS-10-100, RC-11-17 page 1/2 directs:

The planned menu, including snacks, shall provide each resident with a minimum of 1500 millilitres (ml) of fluid per day or the amount ordered by the Registered Dietitian.

Procedure:

Considerations:
The following factors may increase residents risk related to hydration.
-Fluid intake < 1000 ml/day

Residents who have been identified as being at risk nutritionally will have the risks and interventions noted on their plan of care.

Each resident will be provided with a minimum of 1500 ml of fluids in each 24 hour period. This is to be offered at regularly scheduled intervals throughout the day. Each serving of fluid equals 175 ml, morning, evening and at night (AM, PM and HS), snacks will include 175 ml of liquid. All variations will be assessed by the Registered Dietitian and documented on the plan of care.

-All members of the multidisciplinary care team will monitor residents' hydration status as part of routine assessment. Any signs and symptoms of risk related to nutrition must be reported to the registered staff. Residents with persistent symptoms are to be referred to the Registered Dietitian for assessment, using the Dietitian referral.

Each resident's fluid intake for meals and snacks will be monitored and recorded on the Nutritional Intake Record. Residents who consume less than 1000 ml per day are at high nutritional risk and must be referred to the registered dietitian. Registered staff are to monitor total daily intake on an identified shift.

The MOHLTC received a complaint Log #031502-16 on an identified date, related to nutritional concerns of resident #001.

A review of resident #001's written care plan in place after admission to the long term care home, indicated the resident was at an identified nutritional risk and had interventions in place related to the resident's identified estimated fluid requirements per day.

A review of resident #001's Nutritional Intake Record indicated that on six identified dates in an identified month, the resident's documented fluid intake for 24 hours were below the

estimated fluid requirements. There was no documented evidence to indicate that the fluid intakes were recorded for the resident on six separate identified dates in the same month, after two identified meals. There was also no documented evidence on the Nutritional Intake Record to indicate fluid intakes were recorded for resident #001 on four other identified dates in a two month period during on an identified shift.

The resident was hospitalized during an identified month, with an identified diagnosis. There was no documentation of fluid intake for the resident upon return from hospital, on 10 identified dates and shifts.

During an interview with PSW #102 on an identified date and time, indicated to inspector #607 that residents' food and fluid intake are monitored by PSWs and are recorded after each snack and meals in the food and fluid binder.

During an interview with PSW #104 on an identified date and time, indicated to the inspector that staff record residents' intake and output on every shift and staff are to encourage residents to drink fluids. The PSW #104 also indicated that if a resident was at risk for decreased fluid intake, the registered staff would let the front line staff know to monitor the resident’s fluid intake, and whatever the front line staff recorded of residents’ intake, they would inform the nurse in charge.

During an interview with RPN #103 on an identified date and time, indicated to the inspector that residents' fluid intake are monitored and recorded in the Nutritional Flow Sheets after each snack and meal. The RPN further indicated that the night PSWs are responsible for totalling a resident’s 24 hours intake.

During an interview with the Assistant Director of Care (ADOC) on an identified date and time, indicated to the inspector that the licensee's expectation is, residents' fluid intake are to be recorded after each meal and snack, and further indicated that the evening registered staff are responsible for totalling resident's 24 hours intake, to observe if the residents are meeting their fluid requirements. The ADOC also indicated that registered staff are responsible for reporting to the RD as per the criteria for dietary referral, if fluid requirements had not been met.

During an interview with the RD on an identified date and time, indicated to the inspector that resident #001 was at an identified nutritional risk, and further indicated that the staff would send a referral to the RD, if there were three consecutive days of fluid intake of less than 1500 ml within 24 hours. The RD also indicated the licensee's expectation is

that staff would document every time the resident's fluid intake was below the requirement, and the night staff is to check resident's fluid intake and assess the residents. The RD also indicated not receiving a referral related to resident #001's fluid intake by the registered staff.

The licensee has failed to ensure that its Hydration policy #FS-10-100, RC-11-17 was complied with. Specifically related to when resident #001 was at risk nutritionally, there was documented evidence to indicate staff did not record resident #001's fluid intake for identified meals and snacks in the Nutritional Intake Record every shift. There was also documented evidence to indicate that when resident #001 consumed less than the required amounts of fluid per day and was at an identified nutritional risk, the resident was not referred to the Registered Dietitian.

2. The resident sample size was increased to include resident #012, as non-compliance was identified related to nutrition and hydration and documentation.

A review of the Nutritional Intake Records for resident #012 indicated that on 23 identified dates and shifts, over a four month period, there was no documented evidence of the resident's fluid intakes.

3. The resident sample size was also increased to include resident #013, as non-compliance was identified related to nutrition and hydration and documentation.

A review of resident #013's Nutritional Intake Record indicated that on 18 identified dates and shifts, over a four month period, there was no documented evidence of the resident's fluid intakes.

During an interview with PSW #102 on an identified date and time, indicated to inspector #607 that resident's food and fluid intake are monitored by PSWs and are recorded after each snack and meal in the food and fluid binder.

During an interview with RPN #103 on an identified date and time, indicated to the inspector that residents fluid intake are monitored and record in the Nutritional Flow Sheets after each snack and meal.

During an interview with the Assistant Director of Care (ADOC) on an identified date and time, indicated to the inspector that the expectation is resident's fluid intakes are recorded after each meal and snack, and the registered staff are responsible for totalling

a resident's 24 hours intake, to observe if the resident was meeting the fluid requirements and also report to the RD as per the criteria for dietary referral.

The licensee has failed to ensure that its Hydration policy #FS-10-100, RC-11-17 was complied with, specifically related to resident #012 and #013 Nutritional Intake Record had documented evidence to indicate that staff did not record the resident's fluid intake for meals and snacks every shift.

4. The MOHLTC received a complaint Log #031502-16 on an identified date, related to nutritional concerns of resident #001.

A review of the Parkview Home Weight and Height Monitoring policy #RC-09-15 with an approved date, page 1-2 directs:

Residents shall have their weight recorded on admission and monthly. All weights shall be monitored monthly within the first week of each month.

6. An unplanned weight change of 2 kilogram (kg) or more, a reweigh is required.

7. The PSWs are responsible to do the reweigh on their first bath day or evening before the 15th of the month.

8. If reweigh still confirms a weight change of 2.0 kg or more, Dietitian referral must be submitted and documentation of the change in the progress notes.

9. Weight changes of more than 5 percent are referred to the Registered Dietitian, using Dietitian Referral #RC-11-19-01.

A review of resident #001's plan of care that was in place on an identified date, indicated the resident was at high nutritional risk. The goal was for the resident's weight to be maintained an identified weight range over the next quarter.

A review of resident #001's weight record for a six month period, indicated the following:

-Between the first and second month, there was a 2.9 Kg difference.
-Between the fourth and the first month, there was a 3.6 Kg difference;
-Between the fourth and the fifth month, there was a 2.3 Kg difference and;
-Between the fifth and the sixth month, there was 2.5 Kg difference.

A review of the progress notes had no documentation related to resident #001's weight loss for the six identified months, nor was there any documented evidence to indicate that when resident #001 had a weight loss of more than 2.0 Kg in the second, fourth and fifth identified month, a referral was sent to the RD.

During an interview on an identified date and time, PSW #104 indicated to inspector #607 that residents' weights are monitored on the first of every month, and if there was a discrepancy of more or less than 2.5 kg in comparison to the previous months weight, the resident would be reweighed, and if there was still a discrepancy the nurse would be notified.

During an interview with RPN #103 on an identified date and time, indicated to the inspector that residents' are weighed once per month. The RPN also indicated that if a resident’s weight had changed from the previous month, a referral is sent to the RD for weight discrepancies of 2.5 kilograms. The RPN indicated that staff would reweigh the resident and if there was still discrepancies, a referral would have been sent to the RD, and the RD would have completed an assessment.

During an interview on an identified date and time, RPN #109 indicated to the inspector that residents' weights are monitored monthly and are entered in the home’s electronic software by the 15th of every month, and also indicated that a resident was to be reweighed for a discrepancy of an increase or decrease of 2.0 kg weight in comparison to the previous months weight. The RPN further indicated that a resident would have been referred to the RD, if there was a discrepancy of less or more than 2.0 kg in comparison to the previous month's weight.

During an interview with the RD on an identified date and time, indicated to the inspector of only receiving a referral related to resident #001’s weight loss in the six identified month, and further indicated that staff would not send a referral related to the resident's weight loss if the resident was already on an identified supplement.

The licensee failed to ensure that when resident #001 had a weight loss of a difference of 2.9 kg between the first and the second identified months, and a difference of 2.9 kg between the third and fourth identified months, a referral was not sent to the RD. There was also no documentation in progress notes related to the resident's weight loss, as per the home Weight and Height Monitoring policy #RC-09-15, that indicated if a resident's reweigh confirmed a weight change of 2.0 kg or more, a dietitian referral must be

submitted and document the changes in progress notes.

5. Under O. Reg. 79/10, s. 48 - s. 52 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

Under O. Reg. 79/10, 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: 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.

A review of the Parkview Home identified Continence care policy #RC-13-61 directs:

Parkview Home endeavours to reduce the number and frequency of resident transfers to acute care hospital by proving special treatments and procedures on site. It is the responsibility of the registered staff to attain and maintain competence in the implementation of these procedures:

21: Document the identified criteria specific to the treatment, the patient's response to procedure and an identified assessment.

The MOHLTC received a complaint Log #031502-16 on an identified date and month, regarding concerns related to resident #001's continence care.

A review of resident #001's Medication/Treatment Administration Record (MAR/TAR) for a six month time period, indicated there was a physician's order in place with an identified date, the physician orders indicated the resident was to receive an identified treatment with specific interventions.

During an interview with RPN #109 on an identified date and time, indicated to inspector #607 that resident #001 had a physician's order in place for the resident's specific identified treatment and interventions. The RPN also indicated that registered staff are to document after a procedure, the resident tolerance to the procedure, and identified specifics. Staff are to also endorse to the oncoming shift for continued monitoring.

A review of resident #001's clinical health records for a six month time period, and verification with RPN #114 indicated to the inspector that registered staff usually sign for an identified treatment on the MAR, as well as registered staff would document in the progress notes specifics related to the procedure. The RPN also indicated there was no documentation in the progress notes related to the specifics as required. Registered Practical Nurse #114 further indicated that the licensee's expectation is that registered staff should have documented in the progress notes, the specifics, after the resident's treatment on the above four identified months.

During an interview with the ADOC on an identified date and time, indicated to the inspector that the licensee's expectation is that if a resident has a required specific treatment, identified assessments and documentation should be completed.

The licensee failed to ensure its identified continence care policy #RC-13-61 was complied with. Specifically related to when resident #001 had an identified treatment, the treatment was signed for in the Medication Administration Record (MAR) as being completed. Further review of the progress notes had no documented evidence for four identified dates to include, the identified assessments and documentation, as per the licensee's policy. [s. 8. (1) (a), s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations.

Under O. Reg. 79/10, s. 45 (2) - In this section, "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

The MOHLTC received an anonymous complaint Log #031502-16 on an identified date, related to staffing.

Parkview is 128 bed long-term care home.

Inspector #607 reviewed the registered nurse (RN) staffing schedule with the Care Coordinator/Administrative Assistant (CCAA), for a four month time period. The CCAA indicated that they were responsible for the home's staffing schedule for the identified time periods. The CCAA also indicated that RN's were scheduled for shifts from an external agency, because the home did not have a member of the regular nursing staff to cover all the shifts during this time. The CCAA further indicated that there was no planned/extended and or emergency leave when the agency RNs were scheduled.

The CCAA verified with inspector #607 on an identified date and time, while reviewing the RN's schedule, that 35 identified shifts were filled by an agency RN who was not a member of the regular nursing staff at the home. Inspector #607 also reviewed the staffing schedule with both the Administrator and the CCAA on a separate identified date, and they verified with the inspector that over a four month time period, there were 35 identified shifts where an agency RN had been scheduled to work. Further review of the staffing schedule for the same time periods, indicated that there were approximately 12 different RNs that were assigned to cover the identified 35 shifts.

During an interview with the Administrator on an identified date and time, indicated to the inspector that there were times when the long-term care home required the use of RNs from an external agency. The Administrator indicated the home was constantly recruiting RNs, through various modes of advertising.

During an interview with the Staffing Clerk on an identified date and time, indicated to the inspector that the home currently use two external agencies to staff RNs, when staff are unable to come to work.

The licensee has failed to ensure that there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff on duty and present at all times. Specifically related to a review of the staffing schedules with both the Administrator and CCAA on an identified date, verified that between a four month time period, there were 35 identified shifts, where agency RNs were scheduled to work. Further review of the staffing schedules for the same time periods, indicated that there were approximately 12 different agency RNs that were assigned to cover the above identified 35 shifts. [s. 8. (3)]

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 ensuring that there was at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record relating to each annual evaluation of the staffing plan including 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.

The MOHLTC received an anonymous complaint Log #031502-16 in an identified month, related to staffing.

A review of the home's staffing records and interview with the Administrator on an identified date and time, verified with the inspector that there was no written record of an annual evaluation of the staffing plan, but further indicated the plan was discussed yearly at a forum held by the home.

The licensee failed to ensure that there was a written record of each annual evaluation of the staffing plan, including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and date that those changes were implemented. [s. 31. (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 ensuring that a written record of each annual evaluation of the staffing plan including 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, 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

The MOHLTC received a complaint Log #031502-16 on an identified date, related to resident #001 having an injury to an area of unknown cause on two separate identified dates.

A review of resident #001's plan of care at the time the complaint was received by the MOHLTC, identified that the resident had several identified interventions in place related bed mobility.

A review of resident #001's clinical heath records indicated, that the resident had returned from hospital on an identified date, with an injury to a specific area. Further review of the residents' clinical health records indicated, that on an identified date following the return from hospital, RPN #113 documented and verified that during shift change, the RPN was asked to assess resident #001. Upon assessment, the resident was observed lying in an identified position with an identified injured to an area. The resident was later transferred a second time to hospital, and was diagnosed with another injury to the same area.

A review of the investigation notes related to resident #001's injury and interview with PSW #115 on an identified date and time, who was assigned to care for resident #001 on the date of the injury, indicated to inspector #607 that the resident was not repositioned,

and that care had not been provided to resident #001, as the resident did not ring the call bell. The PSW #115 also indicated that they were unaware that the resident had an identified intervention in place or had an injury.

During an interview on an identified date and time, RPN #115 indicated to the inspector that the RPN worked with a PSW from an external agency on the date the resident was injured, and was not able to verify if resident #001 was repositioned during the shift. The RPN also indicated that there was one PSW assigned to 28 residents on the identified shift and one RPN to three units. The RPN also indicated that PSWs are assisted by the RPNs with residents who required two staff assistance with care on the identified shifts.

During an interview with the Administrator on an identified date and time, indicated to the inspector that the licensee's expectation is that staff would have checked resident #001 throughout the shift including repositioning of the resident.

The licensee failed to ensure that when resident #001 had an injury to an identified area, both RPN #116 and PSW #115 indicated the resident required assistance to be repositioned and was not repositioned every two hours during their shift. [s. 50. (2) (d)]

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 ensuring that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

WN #6: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

The MOHLTC received a complaint Log #031502-16 on an identified date related to resident #001 having two identified injuries to an area of the body unknown cause, in two separate identified months.

A review of resident #001's plan of care that was in place in an identified month, indicated the resident had a previous injury and required assistance with bed mobility.

A review of resident #001's Falls Risk Assessment Tool indicated the resident had an assessment completed on an identified date, and had an identified fall risk score. The assessment record indicated that an identified score or greater indicated the resident was at risk for falls.

A review of resident #001's plan of care for a four month period after admission, had no documented evidence of interventions put in place, to address the resident's risk for falls.

During an interview with PSW #101 on an identified date and time indicated to inspector #607 that resident #001 was at risk for falls.

During an interview with RPN #113 on an identified date and time indicated to the inspector, that there were no interventions in resident #001's plan of care related to falls and further indicated that upon the resident's admission, resident #001 was ambulating with the use of a mobility device. The RPN also indicated that the resident was at risk of falls and indicated that if a resident had a fall risk assessment with an identified score, this would place the resident at risk for falls, and the expectation is that interventions be

care planned related to the risk of falls.

During an interview with the DOC on an identified date and time, indicated to the inspector that when a resident was assessed as being at an identified risk for falls, it is the expectation that interventions related to the resident's fall risk be included in the plan of care.

The licensee has failed to ensure that resident #001's plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions, including risk of falls. Specifically related to the resident's plan of care did not have interventions related to falls, when the resident was assessed as being at an identified risk for falls. [s. 26. (3) 10.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident receives assistance to use personal aids, if required.

The MOHLTC received a complaint Log #031502-16, on an identified date related to resident #001 not having an identified device in place and when in place they are non-functioning.

A review of the plan of care for resident #001 that was in place at the time the complaint was received by the MOHLTC, indicated that resident #001's was identified as having an identified impairment and was to use a specific device to assist with the impairment to be in place, as well as, an identified item to the device was to be changed on identified intervals and as needed.

A review of the progress notes with an identified date time, documented by RPN #103 indicated resident #001’s family member voiced concerns that resident #001’s identified device was not given to the resident on the identified date and that the resident had difficulties due to not having the device in place.

The RPN who worked the identified shift, and would have been responsible for applying resident #001’s device was no longer working at the home.

During an interview on an identified date and time, the PSW #104 indicated to inspector #607 that when a resident is to have a specific device in place, the nurse in charge of the unit was responsible for applying the device to the resident and checking the device to ensure that it was working.

During an interview on an identified date and time, RPN #103 indicated to the inspector that resident #001 had a specific device in place and indicated that the registered staff were responsible to ensure that the device was applied on two identified shifts.

During an interview with the ADOC on an identified date, indicated to the inspector that the licensee’s expectation is that if a resident had a specific device to be applied, it should be applied by the registered staff.

The licensee failed to ensure that resident #001's specific device was applied on an identified date, as required. [s. 37. (2)]

Issued on this 1st day of November, 2018

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

Original report signed by the inspector.