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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2014	2014_267528_0032	H-001355-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

DOVER CLIFFS
501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

CYNTHIA DITOMASSO (528), CAROL POLCZ (156), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 8, 9, 10, 14, 15, 16, 17, 20, 2014

This inspection was done concurrently with Critical Incident System Inspection Log #'s: H-000112-14, H-000386-14, H-000091-14

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Food Services Manager (FSM), Environmental Services Manager (ESM), Registered Dietitian (RD), registered nursing staff, personal support workers (PSWs), housekeeping staff, Physiotherapy Assistant (PA), Dietary Aides, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

13 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, was respected.

A) During a lunch service in 2013, resident #62 indicated to staff that they were not feeling well and wanted to go back to bed; however, the Registered Practical Nurse (RPN) insisted that the resident remain in the dining room.

i. Review of the home's investigation notes surrounding the incident indicated that an RPN and personal support workers (PSWs) were in the dining room during the incident. It was identified, in written statements provided by the PSW's, that the RPN did not allow the resident to leave the dining room and did not assist or assess the resident.
ii. In October 2014, interviews were held with the PSW's who were in the dining room on that day. All PSW's confirmed that at the beginning of meal service the resident was in obvious physical distress when entering the dining room. PSW's interviewed stated that two attempts were made to assist the resident back to bed; however, the RPN insisted that the resident remain seated in the dining room. All PSW's stated that the RPN was aware that the resident wanted to go back to bed. A PSW stated that the RPN was notified of the resident's distress but continued to give out medications.
iii. The homes investigation notes and conversations with staff confirmed that PSWs took action to address resident's symptoms, the ADOC was contacted, and the resident was transferred to the hospital.
iv. The home's investigation notes, including interviews with the RPN involved, indicated that the RPN assessed the resident that morning and was aware in the change in condition.
v. The RPN was disciplined.

During that time while the resident was sitting in the dining room, the RPN did not care for the resident in a manner consistent with their needs. From approximately 1200 to 1230 hours, the Registered Practical Nurse insisted that the resident remain in the dining room despite their wishes. The RPN did not assess the resident while in the dining room, and as a result, direct care had to take action.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident's right to be properly sheltered, fed, clothes, groomed and cared for in a manner consistent with his her needs, was respected, to be implemented voluntarily.

WN #2: 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. (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).

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).

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.

A) Resident #17 was noted to have a Personal Assistance Services Device (PASD) tilt wheelchair; however, this was not included on the plan of care for the resident. The ADOC confirmed on October 16, 2014 that the PASD was not on the resident's care plan and that it should be included on the written plan of care to set out the planned care for the resident.

B) During the course of the inspection, resident #20 was observed up in a tilt wheelchair. Staff confirmed that the resident was assessed and occasionally used the tilt function on the wheelchair, as a PASD, on request, and confirmed that this intervention was not included in the plan of care as required. (168) [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A) The Minimum Data Set (MDS) Quarterly Assessment from August 2014, for resident #21, indicated in Section J. 1. "Problem Conditions" that the resident was dehydrated and did not consume sufficient fluids in the three days prior to the assessment. The Dehydration Resident Assessment Protocol (RAP) generated from this assessment, completed by a Registered Nurse, indicated that the resident was below his daily requirement for fluid intake and staff were encouraged to push fluids. The Nutritional Status RAP completed by the Registered Dietitian for this quarter indicated that the resident was meeing his hydration needs and fluid intake was "fantastic". The assessments were not integrated, consistent with or complement each other as confirmed with the DOC on October 15, 2014. [s. 6. (4) (a)]

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

A) The plan of care for resident #21 indicated that the resident would have two falls mats; however, as observed and confirmed with an interview with the DOC, the resident had only one falls matt in place and available. Care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

A) Throughout the course of the inspection, resident #13 was observed to be seated in a wheelchair with a chair alarm, with multiple attempts being made by the resident to rise to standing position but was unable. Review of the plan of care did not reflect the resident's current functional status and interventions as follows:

i. The document the home refers to as the care plan indicated that the resident required one staff assistance with mobility and transfers with use of walker when ambulating,

walking program with physiotherapy twice a week, and one staff to assist during mobility and transfers. In the most recent physiotherapy assessment from September 2014, it was documented that due to physical deterioration and extensive assistance required by the resident, physiotherapy was discontinued.
ii. On October 8 to 10, 2014 the resident was noted to have a chair alarm in place when sitting in wheelchair. The document the home refers to as the care plan did not include any direction to staff that the resident required a chair alarm; however, interviews with both direct care staff and registered staff confirmed that the resident did use the chair alarm daily in order to prevent falls.
iii. The resident's care plan directed staff that the resident required one staff to assist with transfers and when ambulating with a walker; however, the Assessment Form for Lifts and Transfers (SALT) from October 2014, indicated that the resident required extensive assistance of one staff using a transfer belt.

Interview with registered staff confirmed that the resident's plan of care was not updated to include their deterioration in physical function and current falls prevention interventions. [s. 6. (10) (b)]

5. 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 care set out in the plan had not been effective.

A) In September 2014, a progress note written by the FSM indicated that resident #21 was not meeting the daily fluid goal of 1700 ml and the RD would be alerted. Twenty days later, another note written by registered staff indicated that the resident was again below the required 1700 ml per day and a referral would be sent to the RD. As of October 20, 2014 there was no hydration assessment completed for this resident. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
i. there is a written plan of care for each resident that sets out the planned care for the resident.
ii. staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.
iii. the care set out in the plan of care provided to the resident as specified in the plan.
iv. the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Home's policy "LTC-E-50 Continence Care", last revised May 2013, directed staff to complete a three day continence assessment on admission and with any change in incontinence status, including change in incontinent product.

A) Resident #12 was admitted to the home in 2014 with urinary incontinence. The clinical record did not include a three day continence assessment on admission, as required in the home's policy, as confirmed by the DOC, during a clinical record review. (168)

B) Resident #24 was admitted to the home in 2013, with urinary incontinence. Review of the clinical health record did not include a three day continence assessment on admission, as required in the home's policy. Interview with the ADOC confirmed that the three day continence assessment was not completed for the resident. [s. 8. (1) (b)]

2. The home policy LTC-G-80 "Nutrition and Hydration Management", last revised August 2014, was not complied with. Step #5 in the policy outlines that a referral will be made to the RD if the resident's daily fluid intake is recorded as less than the recommended minimum intake from fluids alone for three consecutive days and based on the clinical judgment of the nurse.

A) In August 2014, resident #21 was found to be below the individual assessed hydration needs of 1700 mililitres per day; however, no referral to the RD was completed as confirmed with the FSM on October 16, 2014. The home failed to comply with the Nutrition and Hydration Management policy. [s. 8. (1) (b)]

3. The home's policy "LTC-B-110:Management of Personal Belongings", effective August 2012, indicated that all resident personal belongings will be labeled and recorded on the Resident Personal Belongings Form. The form will be dated and signed by the resident/SDM/family and registered staff then filed in the resident health record.

A) Resident #25 was admitted to the home in 2013. Review of the plan of care did not include a record of resident's personal belongings. Interview with registered staff confirmed that the resident had personal belongings in the home and the Resident Personal Belongings Form was not included in the resident health record. [s. 8. (1) (b)]

4. The Home's policy "LTC-F-20 Medication Administration", last revised August 2012, indicated that all medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse.

A) In January 2014, an RPN attempted to administer seven medications to resident #63, as outlined in the electronic medication administration records (eMARS). Using the

eMAR coding, the RPN documented that two of the oral medications were administered, the remainder of the medications were documented as refused or that the resident was absent from the home.
i. Review of the home's investigation notes confirmed that the RPN crushed all the medications up together and put them in the resident's breakfast. A letter written by direct care staff working that day stated that the resident did not eat the breakfast, and the RPN eventually disgarded the resident's breakfast in the garbage; which included the crushed medications.
ii. In an interview between the ED and the RPN in January 2014, it was confirmed that the resident did not eat his breakfast, and therefore, did not take any medications that morning. The RPN did not use the proper codes when documenting the administration of medications to resident #63 on January 2, 2014. [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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings, and equipment were kept

clean and sanitary.

A) Throughout the course of the inspection, the following observations were made in the shower rooms of the home:

i. the first floor, spa room shower was noted to have dirt and debris on the floor
ii. the second floor, spa room shower, was noted to be covered in soap scum on the floor tiling

Interview with direct care staff on both floors confirmed that only one resident from each floor used the showers and, therefore, were not used daily.

B) During the kitchen walk-through on October 15, 2014, it was noted that the range hood was very dusty and dirty. Other areas in need of a deep clean were the stove area including the switch panel and under the grates, the ovens, the juice fridge, the shelf under the mixer, the knife holder and the industrial can opener. The plastic on the shelving in the juice fridge was noted to be peeling away leaving the shelving difficult to clean thoroughly. All items were discussed and confirmed with the FSM and ESM on October 15, 2104. (156) [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and good state of repair.

A) Throughout the course of the inspection, the following observations were made in the shower rooms of the home:

i. Patching of plaster was noted to the walls throughout the first floor spa room.
ii. Three large cracks were observed throughout the tiling on shower room floor, extending from the drain to the wall in the second floor spa room
iii. From October 8-10, 2014, a large puddle of water was noted to be pooling in a tiled area of the second floor spa room, which was used for storage of resident equipment.

Interview with the ED and ESM confirmed that plans to renovate the first floor spa room were to commence within the next few months; and tiling of the spa rooms, possibly in early 2015. The ESM was not aware of the pooling of water observed in the second floor spa room; however, during the second week of the inspection the water was no longer pooling. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident with altered skin integrity, including skin tears, 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.

A) Resident #25 was identified to have a skin tear in October 2014, according to the clinical record. The progress note regarding this area of altered skin integrity identified the location, size and treatment completed; however, did not include the appearance of

the area, as confirmed during an interviewed with registered staff. The area was not assessed according to the home's management of skin tears document. (168)

B) In February 2014, the MDS assessment for resident #12 identified the presence of four areas of altered skin integrity related to pressure. Registered staff interview and photographs taken confirmed that the resident had multiple wounds in a localized area, most of which had since healed. A review of the clinical record included only one Initial Wound Assessment for one area of altered skin integrity in February 2014, and did not include additional Initial Wound Assessments for the other areas of altered skin integrity, which were identified in the MDS assessment, as confirmed during staff interview. (168) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home and had any changes made to the plan of care related to nutrition and hydration implemented.

A) In April 2014, resident #13 was noted to have a new area of altered skin integrity. Initial assessment of the wound by registered nursing staff indicated that the RD would be notified of the new area of altered skin integrity; however, referrals sent to the RD that same month noted the resident's decreased fluid intake only. Review of the plan of care did not include an assessment by the RD related to the new area of altered skin integrity. Interview with the FSM confirmed that a referral was not sent to the RD by registered staff related to the resident's altered skin integrity.

B) Resident #25 sustained a skin tear in October 2014, according to the clinical record, which identified "will send a ref to the dietitian for a new wound". A review of the record did not include an assessment of the altered skin integrity by the RD. Interview with FSM on October 15, 2014, confirmed that she nor the RD received a referral for the area of altered skin integrity and that the RD confirmed by phone that an assessment related to the area was not completed. (168) [s. 50. (2) (b) (iii)]

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

A) In April 2014, resident #13 had a new area of skin breakdown. The following month, a treatment cream was ordered by the physician and applied to the area until the area was

healed, in June 2014. Review of the plan of care did not include weekly assessments in May 2014, for four weeks. Interview with registered staff confirmed that the weekly assessments were not completed in May 2014, for four weeks until the area was healed.

B) Resident #12 was identified to have multiple wounds in a localized area according to photographs, staff and the February 2014, MDS assessment; which identified the presence of four areas of altered skin integrity. In October 2014, the resident had only one area of altered skin integrity being treated by registered staff. A review of the Treatment Observation Record (TOR) - Ongoing Wound Assessments completed since the February 2014 MDS assessment, identified that at least one wound assessment was being completed consistently on a weekly basis; however, the available records did not include a TOR - Ongoing Wound Assessment completed weekly for each of the wounds identified, as confirmed during staff interview. (168) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
i. the resident with altered skin integrity, including skin tears, 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. the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home and any changes made to the plan of care related to nutrition and hydration implemented.
iii. the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that residents who have taken any drug or combination of drugs, had monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A) Resident #20 reported the presence of pain. A review of the clinical record confirmed that a new analgesic was ordered in June 2014. The dosage of the medication was changed three days later and again in July 2014, and changes to the dosage of a second analgesic in July 2014. The clinical record did not include ongoing monitoring or documentation of the effectiveness of the drugs in the progress notes or a pain monitoring tool, as required, as confirmed during an interview with the registered staff. (168)

B) MDS assessments from December 2013 to present indicated that resident #24 had mild pain daily. In February 2014, a change in narcotic orders were noted from administration on an as needed basis to routine administration. Review of the plan of care did not include monitoring of the resident's response and effectiveness of the drug in either the progress notes or pain monitoring tool, as required. Interview with registered staff confirmed that the resident was not monitored for their response or effectiveness of the drug following a change in narcotic orders. (528) [s. 134. (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 residents who have taken any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

A) In October 2014, direct care staff found resident #61 in the north stairwell, no injury or harm was noted to the resident.

i. Review of the plan of care indicated that the resident was impaired cognitively, had an unsteady gait with a tendency to wander requiring supervision.
ii. Review of the incident note confirmed the resident entered the stairwell and was unable to unlock the door to get back onto the unit. Staff heard the resident in the stairwell and assisted him back to the appropriate care area.
iii. Observation of the north stairwell confirmed that the door was closed and locked with a keypad; however, after code was punched into the keypad the door remained unlocked for approximately twenty seconds. Access from the stairwell included an unlocked door, with keypad, to outside, and locked doors to all three floors of the home.
iv. Interview with ESM confirmed that the keypad doors remained unlocked for twenty seconds after code was used. Interview with ED confirmed the incident surrounding resident #61 was isolated; however, it was the responsibility of staff to ensure that all doors were locked after use.

The environment was not kept safe and secure when resident #61 was found in the north stairwell by staff. [s. 5.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

The home's policy "LP-C-20-ON Resident Non-Abuse-Ontario", last revised September, 2014 indicated that external reporting to the Director is mandatory under Section 24(1) of the LTCHA, and that any person who had reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information which it is based on to the Director of the Ministry of Health and Long Term Care.

A) A written letter from December 2013, signed by three staff members, alleged that in December 2014, resident #62 was mistreated by the RPN working that day. In review of the Critical Incident Report, it was noted that the home did not report the allegations until January 15, 2014. The home's investigation notes included documentation dated January 3, 2014, that confirmed the home was aware of the incident on December 24, 2014, at which time the original letter was read. [s. 20. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week, unless contraindicated by a medical condition.

Resident #12 identified that they recently missed three baths due to personal outings. A review of Point of Care (POC) documentation identified that the activity of bathing "did not occur" on three days in September 2014, as scheduled. Documentation reviewed identified they received an unscheduled bath on one day that month, due to the missed baths. There was no documentation evident to support additional unscheduled baths were completed for the other two originally planned bath days, to ensure that the resident received bathing at a minimum of twice a week. (168) [s. 33. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of the tilt wheelchair PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if: the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Throughout the course of the inspection, resident #17 was observed to be using a tilt wheelchair as a PASD. Review of the plan of care did not include consent for the use of the tilt wheelchair. The use of the tilt wheelchair as a PASD was not consented to, as confirmed with the ADOC on October 16, 2014. [s. 33. (4) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to meet the needs of residents with compromised communication and verbalization skills.

A. Resident #18 was noted to have a communication impairment related to aphasia causing frustration when unable to communicate.

i. Interview with the resident's substitute decicision maker (SDM) indicated that a communication binder was put together by family to assist the resident communicate with staff and family. Family reported that whenever they visit the binder is not easily accessible to the resident; and they are unsure if staff are using the binder, as requested.
ii. The document the home refers to as the care plan directed staff to use simple questions when speaking with the resident, allow time for resident to response, and to consult family for best approaches and strategies to help increase communication; however, did not include the use of the communication binder.
iii. Throughout the course of the inspection, the binder was noted to be sitting on the resident's bedside table with resident's belongings piled on top.
iv. Interview with regular direct care staff confirmed that staff were aware of the binder, and it was not accessible to the resident. Registered staff confirmed the binder was not included in the care plan as a communication tool; therefore it was not always implemented. [s. 43.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

A. Throughout the course of the inspection, lingering and offensive odours were noted in the hallway on second floor, outside of room 201, and in the shared resident bathroom of room 104. Interview with the ESM confirmed that the home was aware of the odours and had trialed different cleaning strategies to try and combat the odors; however, the Corporate Representative was unable to to locate a formalized policy in the home for lingering and offensive odours. [s. 87. (2) (d)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment

by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment, and any significant change in resident's condition, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.
For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the ARD.
b) RAPs must be generated and reviewed and RAP assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the ARD.
The licensee did not comply with the conditions to which the license was subject. The following residents did not have RAP assessment summaries completed for non-triggered clinical conditions as required.

A) Resident #20 was coded in MDS assessments completed in March 2014, June 2014 and August 2014, with the presence of daily pain of moderate intensity, in multiple locations. A review of the clinical record did not include RAP's for the presence of pain as a non-triggered clinical condition. Discussion with the RAI Coordinator confirmed that the home did not create specific pain RAPs, but if appropriate would include their assessment finding in another RAP. A review of the RAPs created based on the August 2014, MDS assessment only included an assessment related to dental pain, as confirmed by registered staff.

B) Resident #12 received narcotic analgesics and was coded in MDS assessments completed in February 2014, May 2014 and September 2014, with the presence of daily pain of moderate intensity, in multiple locations. A review of the clinical record did not include specific pain RAPs for the resident. A review of the RAPs completed for the September 2014, MDS assessment included relevant diagnosis related to pain although did not include an assessment related to the daily pain experienced by the resident. (168)

C) MDS Quarterly Assessments from December 2013, to present, indicated resident #24 had mild pain daily. Review of the plan of care confirmed that the resident was receiving routine analgesia for pain. The non triggered RAPs for pain were not completed quarterly. Interview with ADOC confirmed that the RAPs for pain were not completed for the resident. (528) [s. 101. (4)]

Issued on this 24th day of November, 2014

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

Original report signed by the inspector.