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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2016	2016_341583_0010	015876-16	Resident Quality Inspection

Licensee/Titulaire de permis

FOYER RICHELIEU WELLAND
655 Tanguay Ave WELLAND ON L3B 6A1

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

FOYER RICHELIEU WELLAND
655 TANGUAY AVENUE WELLAND ON L3B 6A1

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

KELLY HAYES (583), CATHY FEDIASH (214), PHYLLIS HILTZ-BONTJE (129)

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): May 25, 26, 27, 30, 31 and June 1, 2, 3, 7, 8, 9, 10, and 13, 2016.

Please Note: The following inspections were conducted simultaneously with this Resident Quality Inspection:
-Complaint Inspection #002685-15 related to alleged staff to resident abuse.
-Complaint Inspection #016501-16 related to foot care.
-Follow up Inspection #035142-15 related to the plan of care being reviewed and revised.

During the course of the inspection, the inspector(s) spoke with the Chief Administrative Officer; Director of Care (DOC); Resident Assessment Instrument (RAI) Co-ordinator; Maintenance Supervisor; Volunteer Co-ordinator/Manager of Foundation; Registered Staff; Personal Support Workers; Food Service Manager; residents and residents' family members. During the course of this inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed relevant policies and procedures; reviewed investigation records; reviewed staff training records and observed residents' in dining and care areas.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **13 WN(s)**
- **4 VPC(s)**
- **2 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. (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 the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

Resident #110's written plan of care did not provide clear directions to staff who provided direct care to the resident in relation to oral care. Staff #042 confirmed that resident #110 required set up only for oral care and the resident was able to complete the process of oral care by themselves. A review of the written plan of care, both the care plan and the kardex did not provide directions related to the amount of assistance the resident required or the equipment the resident was to be provided with in order to complete oral

care. During an interview with staff #042 they confirmed that the kardex was used by direct care staff when determining the level of assistance residents required for care as well as equipment and/or supplies that may be required for care. At the time of this interview staff #042 also confirmed that the written plan of care for resident #110 did not provide clear directions to staff in relation to the level of assistance the resident required or the equipment the resident required to complete oral care. [s. 6. (1) (c)]

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

A) A review of resident #103's quarterly Minimum Data Set (MDS) coding on an identified date in December 2015, indicated under section H. – Continence in the last 14 days that the resident was coded as a three (3) frequently incontinent of bladder. The quarterly MDS coding on an identified date in March, 2016, indicated under section H. that the resident was coded as a four (4) incontinent of bladder. The coding indicated that there had not been any change in the resident's urinary continence as compared to their status 90 days prior. A review of the corresponding narrative Resident Assessment Protocol (RAP) for urinary incontinence indicated that there were no significant changes during this review period.

An interview with the RAI Coordinator confirmed that the assessments completed above were not integrated, consistent and had not complemented each other in regards to the decline in resident #103's urinary continence. (214)

B) A review of resident #104's clinical record indicated that on an identified date in May, 2016, the resident was attempting to self-transfer from their bed to the bathroom and sustained a fall that resulted in an injury.

An interview with registered staff #053 on June 9, 2016, indicated that the resident was capable of understanding the need to call for assistance but at times would not wait for staff to respond and attempted to self-transfer on their own.

A review of the electronic Fall Risk Assessment completed in the Point Click Care (PCC) system documented on an identified date in May 2016, indicated under gait analysis that the resident had multiple risks related to self transferring. A review of a physiotherapy assessment that was completed on an identified date in May 2016, as a result of this fall,

indicated that the resident had been non-compliant with specific identified safety instructions and may continue to place themselves at risk by performing independent and unsafe transfers and would benefit from the use of every two hour checks.

An interview with the RAI Coordinator confirmed that the every two hour checks had not been implemented for the resident and that staff involved in the different aspects of care of the resident had not collaborated with each other in their fall assessments of the resident and that their assessments had not been integrated, consistent and had not complemented each other. (214)

C) A review of resident #109's quarterly MDS coding on an identified date in November 2015, indicated under section H. – Continence in the last 14 days that the resident was coded as a three (3) frequently incontinent of bladder. The following quarterly MDS coding on an identified date in March 2016, indicated under section H. that the resident was coded as a four (4) incontinent of bladder. The coding indicated that there had not been any change in the resident's urinary continence as compared to their status 90 days prior. A review of the corresponding narrative RAP for urinary incontinence indicated that there were no changes in the resident's urinary functioning during this review period.

An interview with the RAI Coordinator confirmed that the assessments completed above were not integrated, consistent and had not complemented each other in regards to the decline in resident #109's urinary continence. [s. 6. (4) (a)]

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

A review of the swallowing recommendations put in place on an identified date in November 2015, recommended resident #102 have oral care completed after each meal. A review of the daily oral hygiene routine recommendations on an identified date in April 2016, directed staff to rinse resident #102's mouth with water after each meal.

On June 1 2016, resident #102 was observed from the beginning of lunch service until 1400 hours, and it was identified that oral care was not provided after the resident completed their meal. In an interview with staff #028, #032, #034 and #035 at 1400 hours it was identified staff had not yet provide oral care and it was confirmed that the swallowing and the oral hygiene recommendations located in the residents plan of care were not provided as specified in the plan. (583) [s. 6. (7)]

4. The licensee failed to ensure that residents were reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed.

A) Resident #100 was not reassessed and their care plan was not reviewed and revised when it was identified that the resident began to experience pain. Registered staff documented on a MDS review completed on an identified date in January 2016, that the resident experienced no pain and then documented on the following MDS review completed on an identified date in April 2016, that the resident had experienced pain less than daily at a mild level. Resident #100's clinical record indicated that the resident's physician ordered the resident to receive a specified amount of pain medication three times a day and a review of the Medication Administration Records (MAR) indicated the resident received this medication through March, April and May 2016.

During an interview on June 2, 2016, the RAI Coordinator and the clinical record confirmed that the data collected on an identified date in April 2016, represented a change in the resident's condition, staff had not completed the RAI-MDS assessment when they did not complete a non-triggered Resident Assessment Protocol (RAP) related to pain and the clinical record did not contain a reassessment of the pain the resident experienced. The RAI Coordinator also confirmed that when it was identified that the resident experienced pain, the plan of care had not been reviewed or revised and at the time of this inspection there was not a care focus related to pain management in the resident's plan of care. (129)

B) Resident #103 was not reassessed and their care plan was not reviewed and revised when it was identified that the resident began to experience pain. Registered staff documented on a MDS review completed on an identified date in December 2015, that the resident experienced no pain and then documented on the following MDS review completed on an identified date in March 2016, that the resident had experienced pain less than daily at a moderate level. The resident's plan of care indicated the resident's physician had ordered the resident to receive a specified amount of pain relief medication twice a day and a review of the MAR indicated the resident received this medication through March, April and May 2016.

During an interview on June 2, 2016, the RAI Coordinator and the clinical record confirmed that the data collected on an identified date in March, 2016, represented a change in the resident's condition, staff did not complete the RAI-MDS assessment when they did not complete a non-triggered RAP related to pain and the clinical record did not

contain a reassessment of the pain the resident experienced. The RAI Coordinator also confirmed that when it was identified that the resident experienced pain, the plan of care had not been reviewed or revised and at the time of this inspection there was not a care focus related to pain management in the resident's plan of care. (129)

C) During an interview with a family member of resident #103, it was communicated that the resident recently had a change in their incontinent product size as the previous product was too small. It was indicated that the current size was too large and there was no product in between.

An interview with staff #066 on June 1 2016, indicated that at the start of their shift the resident was wearing a large/extra-large incontinent product and that following their bath later on the same day, the resident was wearing a medium/regular sized incontinent product. Staff #066 confirmed that the size of incontinent product was too small causing product lines to be noted on the resident's skin. An interview with staff #036 on June 1, 2016, confirmed that the medium/regular sized incontinent product was noted to be too small approximately three weeks – one month ago and that the current large/extra-large product was too big.

An interview with the RAI Coordinator who managed the continence program and staff #032 who was a member of the home's continence program indicated that the home used an assessment titled, "TENA Portraits- Quick Reference Guide" to determine the type of product to be used and that the resident's weight was used to determine the size of the product. It was indicated that if the resident weighed 185 pounds or less, they were to use the medium/regular size and if they weighed more than 185 pounds, they were to use the large/extra-large size. Staff #032 indicated that the most current assessment completed for the resident was in December 2015 and indicated that the resident was assessed to use the medium/regular size product. The RAI Coordinator and staff #032 confirmed that a referral had not been received from staff to reassess the resident's incontinent product. A telephone interview with the incontinent product representative on June 7, 2016, indicated that using weight alone was an informal guide for measuring and usually done on admission and that sizing which involved measuring the waist and hips was then to be conducted. A review of the resident's current written plan of care indicated under bladder and bowel incontinence with an identified initiated date in February 2014, that the resident was to wear a medium sized incontinent product.

The RAI Coordinator confirmed that the resident was not reassessed and their plan of care was not reviewed and revised when their care needs related to their type and size

of incontinent product had changed. The RAI Coordinator confirmed that the resident had now been reassessed and a new incontinent product had been implemented on a trial basis. (214)

D) A review of the home's "concern or complaint investigation form" documented on an identified date in May 2016, identified resident #102's family notified the DOC that they were concerned direct care staff were not following recommendations put in place registered staff.

On an identified date in June 2016, Long Term Care (LTC) Inspector #583 observed staff #035 feeding resident #102 in the dining room during lunch service. LTC Inspector #583 observed staff feeding the resident and identified two of the swallowing recommendations were not being followed. In an interview with the with staff #035 it was identified that they were not aware of these two recommendations.

A progress note documented on an identified date in November 2015, by staff #053 identified resident #102's family brought forward a concern that they observed staff not following the recommendations.

A review of resident 102's plan of care identified they were at high nutrition risk and were referred to SLP for feeding and swallowing problems. The resident was assessed by the SLP on an identified date in November 2015, and several recommendations were made.

Resident #102's progress notes were reviewed for an identified time period in 2016. It was documented five times over the identified time period that resident #102 displayed swallowing difficulties related to eating.

Resident #102's eating focus care plan was reviewed and it was identified that the eating and feeding recommendations had not be added and that the care plan was last revised on an identified date in October 2015. In an interview with staff #053 on June 1 2016, it was confirmed that eating care plan interventions were not revised when resident #102's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessments of residents so that their assessments are integrated, consistent and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. 1. The licensee failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with prevailing practices to minimize risk to the resident and steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [15(1)]

A) Staff did not assess the resident in accordance with prevailing practices when bed rails were used as a care intervention.

i) During stage one of the Resident Quality Inspection (RQI) LTC Inspectors #129, #214 and #583 identified a number of situations that lead them to question bed safety for a number of residents. The Resident Assessment Instrument (RAI) confirmed during stage one staff interviews, that all 65 beds in the home were equipped with quarter bed rails and all 40 residents surveyed as part of the initial phase of this inspection were identified as using bed rails. The Director of Care (DOC), the RAI Coordinator and registered staff # 053 confirmed that the home had not developed an individualized resident assessment to be implemented when staff considered including a care intervention that involved the use of bed rails and that no resident in the home had been assessed prior to the implementation of bed rails as a care intervention. The DOC confirmed that the home was familiar with the guidance document "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", 2003 developed by the Hospital Bed Safety Workgroup which included the Medical Devices Bureau of Health Canada, which has been identified by Health Canada as a resource to be used in the assessment of residents when the use of bed rails were considered. Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails.

B) Staff did not assess the resident's bed system in accordance with prevailing practices when bed rails were used as a care intervention. Prevailing practices are identified in the guidance document, published by Health Canada, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards", revised 2008 and which has been identified by Health Canada as a resource to be used in the assessment of the resident's bed system when use of bed rails were considered. This guidance document indicated "reassessment of the bed system may be appropriate when components of the bed system (e.g., new bed rails or mattresses are changed or replaced".

i) A review of the bed entrapment audit completed by the staff in the home on August 24, 2015 and a review of the bed components in use at the time of this inspection confirmed bed #21 had not been reassessed when a bed component had been changed. Bed 21 was noted to be equipped with "ZF#25" mattress (which was not an air mattress) at the time of the August 2015 bed entrapment audit. At the time of this inspection it was noted that bed 21 was equipped with an air mattress. The DOC confirmed that the resident in this bed had resided in this room since the time of the August 2015 bed entrapment audit, the bed frame had not changed and also confirmed that when the mattress

component of this bed system was changed the bed system had not reassessed related to potential entrapment zones.

ii) It was confirmed by the DOC and Maintenance Supervisor (MS) that bed 24-2, 30-2, 44 and 49 were equipped with air mattresses at the time of the August 2015 bed entrapment audit. At the time of this inspection it was confirmed that the above noted beds where no longer equipped with air mattresses and when this component of the bed system was changed these bed systems had not been reassessed assessed related to potential entrapment zones.

C) Staff in the home did not take steps were to prevent bed entrapment, taking into consideration all potential zones of entrapment in accordance with the prevailing practice document published by Health Canada" Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards", revised 2008.This document indicated "While entrapments have occurred with the use of air mattress replacements, these products are excluded from the dimensional limit recommendations. This partial exemption is due to the highly compressible nature of these mattresses. When these products are used, Health Canada recommends that steps be taken to ensure that the therapeutic benefits outweigh the risk of entrapment"

i) At the time of this inspection it was noted that four bed systems in the home included air mattresses as a component of the bed system. The above noted guidance document indicated "While entrapments have occurred with the use of air mattress replacements, these products are excluded from the dimensional limit recommendations. This partial exemption is due to the highly compressible nature of these mattresses. When these products are used, Health Canada recommends that steps be taken to ensure that the therapeutic benefits outweigh the risk of entrapment" It was noted that bed 21, 1, 12-2 and 50-1 contained air mattresses and bed rails and there were no components or accessories noted in place on these bed systems to mitigate the risk of entrapment. The DOC and MS confirmed that bed systems equipped with air mattresses were only assessed for entrapment related to zone seven (between the head or foot board and the end of the mattress). Following a review of these bed systems on July 9, 2016 with the DOC and the MS it was confirmed that steps had not been taken to mitigate the potential risk of entrapment for the resident's in these beds.

ii) At the time of this inspection it was noted that three bed systems were observed to not be equipped with mattress keepers, the mattresses slid easily from side to side on the bed decks, were equipped with quarter bed rails with either one or both of those bed rails

noted in the up position and there were no components or accessories noted in place on these bed systems to mitigate the risk of entrapment. The above noted guidance document directs that in relation to zones of entrapment three (between the rail and the mattress) and four (under the rail at the ends of the rail) that "the space should be small enough to prevent head entrapment taking into consideration any lateral shift of the mattress. Bed 51, 47-1 and 26-1 were all noted to have significant lateral movement of the mattresses on the bed deck and the mattresses were not secured within accessories to prevent this lateral movement. Following a review of these bed systems on July 9, 2016 with the DOC and the MS it was confirmed that steps had not been taken to mitigate the potential risk of entrapment for the resident's in these beds. [s. 15. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 directions contained in the home's Pain Management policy were in compliance with all applicable requirements under the Act. [8(1)(a)]

The licensee's policy "Pain Management" identified as #07-00-10, located in the Resident Services Manual and dated February 2016, did not comply with the requirement identified in LTCHA, 2007, c. 8, s. 6(10) (b) which required the licensee to reassess the resident and review and revise the plan of care when the resident's care needs changed.

This policy directed registered staff that "if pain is identified as a problem on the comprehensive assessment and scores two (2) or greater on Pain Outcome Measure Scale (POMS) following completion of the RAI-MDS 2.0, then initiate a written plan of care within 24 hours".

An interview on June 2 2016 with the RAI Coordinator confirmed that resident #100 was identified having experienced pain daily at a mild level when the Minimum Data Set (MDS) form was completed on an identified date in April, 2016, which resulted in a POMS score of one (1). Resident #103 was identified as having experienced pain less than daily at a moderate level when the MDS form was completed on an identified date in March 2016, resulted in a POMS score of one (1) and that this documentation represented a changed in both residents' condition. The RAI Coordinator and clinical records confirmed that staff had followed the direction contained in the home's policy, had not complied with the requirement contained in the Long Term Care Home Act to review and revise a resident's plan of care when the care needs of the resident change and at the time of this inspection resident #100 and resident #103 did not have plans of care that identified pain management as a care focus despite staff identifying that these residents' condition changed when they began experiencing pain. [s. 8. (1) (a)]

2. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A) The licensee failed to ensure that directions contained in the home's "Pain Management", identified as # 07-00-10 with a revised date of February 2016 policy, were complied with.

(i) This policy directed that "registered staff were to evaluate to determine if pain strategies were effective and after a new analgesic is begun, the resident's pain will be assessed daily times seven days". Staff did not comply with this direction when it was identified that the pain management strategies in place for resident #105 were not effective and the resident's physician ordered a change in medication. The RAI Coordinator confirmed that registered staff would document this daily assessment in the progress note section of the computerized record. The RAI Coordinator and the clinical record confirmed that staff did not comply with the home's policy when on an identified date in December 2015, with an identified amount of pain medication to be administered twice a day was ordered for the resident in order to manage pain the resident experienced and the clinical record indicated that the effectiveness of this new medication was not assessed until six days later when staff documented on an identified

date in December 2015, that there had been no ill effects from the new medication.

(ii) This policy directed that "for any resident scoring two (2) or above on a Pain Outcome Measure Scale (POMS) following completion of the Resident Assessment Instrument-Minimum Data Set 2.0 (RAI-MDS) that staff were to complete a non-triggered pain Resident Assessment Protocol (RAP). The RAI Coordinator confirmed that above noted RAP was not available to staff in the assessment tab of the computerized record and staff would be expected to complete this RAP in the progress note section of the computerized record. The RAI Coordinator and the clinical record confirmed that when the MDS tool was completed for resident #105 on an identified date in November 2015, the resident was identified as having pain daily and at times the pain was horrible/excruciating which resulted in a POMS score of three (3) and staff did not comply with the home's policy when they did not complete a non-triggered pain RAP. (129)

B) A review of the home's policy titled, Bladder and Bowel (13-00-01 and dated with a revised date of June 2015) indicated the following:

i) when a resident's RAI/MDS review was due, if the resident's continence level decreases compared to the previous quarter, the RN would initiate a three day voiding and bowel record. The RN would initiate the paper documentation task in Point of Care (POC) so that the front line staff would be aware the paper assessment was to be completed. The RN will complete the bladder and bowel assessment again.

A review of resident #101's quarterly MDS on an identified date in January 2016, indicated under section H.- Continence in Last 14 Days that the resident was coded as a one (1) usually continent of bowel. The following quarterly MDS coding on an identified date in April 2016, indicated under section H. that the resident was coded as a three (3) frequently incontinent of bowel. A review of the corresponding narrative Resident Assessment Protocol (RAP) on an identified date in April, 2016, indicated that there were changes to the resident's bowel continence this review period. A review of the resident's clinical record indicated that a three day bowel record and a bowel assessment were unable to be located following the resident's decline in their bowel continence level.

An interview with the RAI Coordinator confirmed that the resident's bowel continence level had decreased over the quarterly review. The RAI Coordinator confirmed that a three day bowel record and a bowel assessment had not been completed and that the home had not complied with their policy related to continence care. (214)

ii) When a resident's RAI /MDS review was due, if the resident's continence level decreased compared to the previous quarter, the RN would initiate a three day voiding and bowel record. The RN would initiate the paper documentation task in POC so that the front line staff were aware the paper assessment was to be completed. The RN would complete the bladder and bowel assessment again. A review of resident #103's quarterly MDS an identified date in December 2015, indicated under section H. - Continence in Last 14 Days that the resident was coded as a three (3) frequently incontinent of bladder. The following quarterly MDS coding on an identified date in March, 2016, indicated under section H. that the resident was coded as a four (4) incontinent of bladder. A review of the resident's clinical record indicated that a three day bladder record and a bladder assessment were unable to be located following the resident's decline in their bladder continence level.

An interview with the RAI Coordinator confirmed that the resident's bladder continence level had decreased over the quarterly review. The RAI Coordinator confirmed that a three day bladder record and a bladder assessment had not been completed and that the home had not complied with their policy related to continence care. (214)

iii) When a resident's RAI/MDS review was due, if the resident's continence level decreased compared to the previous quarter, the RN would initiate a three day voiding and bowel record. The RN would initiate the paper documentation task in POC so that the front line staff would be aware the paper assessment was to be completed. The RN would complete the bladder and bowel assessment again. A review of resident #109's quarterly MDS on an identified date in November 2015, indicated under section H. - Continence in Last 14 Days that the resident was coded as a three (3) frequently incontinent of bladder. The following quarterly MDS coding on an identified date in March, 2016, indicated under section H. that the resident was coded as a four (4) incontinent of bladder. A review of the resident's clinical record indicated that a three day bladder record and a bladder assessment were unable to be located following the resident's decline in their bladder continence level.

An interview with the RAI Coordinator confirmed that the resident's bladder continence level had decreased over the quarterly review. The RAI Coordinator confirmed that a three day bladder record and a bladder assessment had not been completed and that the home had not complied with their policy related to continence care. [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 policy is complied with, to be implemented voluntarily.

WN #4: 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. The licensee failed to ensure that the written record relating to the Pain Management Program evaluation contained the dates the identified changes were implemented.

The DOC provided a document identified as "Pain Management Program 2015 Annual Evaluation". Program deficiencies identified during this program evaluation included the use of the reassessment tool and pain care planning. Strategies to address the identified deficiencies were to update the policy and educated staff. The document did not contain the dates the noted strategies were implemented. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under the continence care and bowel management program including interventions were documented.

A review of the March 2016, quarterly continence assessment for resident #102 identified they were frequently incontinent of urine and required scheduled toileting, use of a pads or briefs and required total assistance with toileting. Resident #102's toileting care plan directed staff to toilet resident #102 at five specific times.

A memo sent out by the DOC on an identified date in March 2016, directed staff to document all times resident #102 was toileted in POC. A review of the POC records over an identified one month period in 2016, identified the resident was toileted once per shift for a total of three times per day. Thirteen of the 35 scheduled toileting times were documented.

In an interview with RAI Coordinator on May 31, 2016, it was shared that staff document toileting once per shift. Therefore there was no documentation to identify if the resident received toileting at their scheduled time or if the resident was continent or incontinent at their scheduled time. In was confirmed that not all actions taken with respect to resident #102's continence care interventions were documented. [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 written records related each evaluation under paragraph three are kept that include the date of the evaluation, the names of the persons who participated in the evaluation, and 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A) A review of the May 2016, quarterly continence assessment for resident #106 identified they were occasionally incontinent of urine and required scheduled toileting, use of a pads or briefs and required extensive assistance with toileting. Resident #106's toileting care plan directed staff to toilet resident #106 at five identified times.

Resident #106 was observed on June 1, 2016, from 1030 hours to 1330 hours, during this time period it was observed the resident was not toileted by staff. Long Term Care (LTC) Inspector #583 observed resident #106 enter another resident's room at 1315 hours and informed staff #035. In an interview with the resident it was confirmed that resident #106 toileted them-self without assistance.

In an interview with staff #028, #032, #034 and #035 at 1400 hours it was confirmed staff

did not toilet or assess resident #106's continence product for wetness for two scheduled times in a row. In an interview with staff #059 it was identified that resident #106 was not to toilet independently due to safety and hygiene requirements. It was confirmed resident #106 did not receive the assistance they required from staff to manage and maintain their continence. (583)

B) A review of the March 2016, quarterly continence assessment for resident #102 identified they were frequently incontinent of urine and required scheduled toileting, use of a pads or briefs and required total dependence with toileting. Resident #102's toileting care plan directed staff to toilet resident #102 at five specific times.

In a progress note documented on an identified date in January 2016, by staff #053 it was identified family made a complaint that resident #102 had not been toileted per their scheduled times between 0930 and 1630 hours. Per the documented progress notes on two identified dates in March, 2016, family discussed toileting concerns with the home and the home confirmed resident #102 scheduled toileting times.

Resident #102 was observed on June 1, 2016, from 1045 hours to 1400 hours, during this time period it was observed the resident was not toileted by staff. In an interview with staff #028, #032, #034 and #035 at 1400 hours it was confirmed staff did not toilet or assess resident #102's continence product for wetness at two scheduled times.

At 1440 hours LTC Inspector #583 observed resident #102 being toileted by staff #061 and #062. The residents brief was observed to be saturated with urine and was changed by staff. In an interview with staff #059 it was confirmed that resident #102 did not receive the assistance they required from staff to manage and maintain their continence. [s. 51. (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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to mange and maintain continence, to be implemented voluntarily.

WN #6: 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 each resident of the home was bathed by the method of his or her choice.

During a family interview on an identified date in May 2016, it was identified that resident #106's preference was to have a bath but they received a shower. In an interview with resident #106 on an identified date in May 2016, they shared they preferred to have a bath.

A review of resident #106's bathing care plan identified their preference initially documented in September 2014, was to have a shower. No documentation was available in the plan of care to identify how this was determined.

In an interview with the RAI MDS Coordinator on May 31, 2016, it was confirmed that there wasn't a process in place to review residents bathing preferences after admission. It was shared that staff would follow the direction in the care plan on bath days and it would not be routine for staff to ask the resident their preference. It was confirmed that resident #106 was not being bathed by a method of their preference. [s. 33. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A review of the progress notes documented on an identified date in 2015, identified resident #200's family member notified staff that the resident's foot care had not been done. An assessment was completed by staff #053 which noted resident #200's nails were very long and in need of nail care. On an identified date in 2015, nail care was provided by staff #074 and it was documented that nails were "very long". It was documented that when foot care was provided two nails fell off one of the resident's foot and one nail had to be removed on the the other foot that was hanging on the edge.

A review of the bathing care plan in place at the time of the incident identified resident #200's nails were to be manicured on bathing day. It was confirmed that to their knowledge resident #200 was to receive basic foot care on bath days. In an interview with the DOC on June 13, 2016, it was confirmed that resident #200 did not receive preventive and basic foot care services that included the cutting of toenails.

PLEASE NOTE: This non-compliance was identified during a Compliant Inspection, log# 002685-15, conducted concurrently during this Resident Quality Inspection. [s. 35. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that resident's desired rest routines were supported to promote comfort, rest and sleep.

During a family/designate interview conducted on an identified date in May 2016, it was shared that resident #102's rest routine was not always supported. A review of the plan of care identified resident #102 required a rest for an identified period in the afternoon.

During an observation on an identified date and time in June 2016, resident #102 was observed to be up in their wheelchair. In an interview with staff #061 and #062 it was confirmed resident #102's afternoon rest routine was not supported. During a second observation on an identified date in June 2016, resident #102 was observed to be up in their wheel chair at 1500 hours. In an interview with the DOC it was confirmed resident #102's afternoon rest routine was not supported. [s. 41.]

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

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care, written strategies/techniques/interventions and resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviours.

The Documents provided by the home that describes the home's responsive behaviour management program did not document written approaches for staff in accordance with the requirements in this Regulation. The home provided the following documents:
i) subject "Responsive Behaviours" identified as # 10-00-01, dated May 2016, that was located in the Behavioural/Montessori section of the Resident Services Manual
ii) subject "Mini Mental Examination" identified as #10-00-02,dated December 2014, that was located in the Behavioural/Montessori section of the Resident Services Manual
iii) title "Internal Process Resident Responsive Behaviours" identified as #10-00-05,

dated May 2016, located in the Behavioural/Montessori section of the Resident Services Manual
iv) subject "Employee/Resident Protection" identified as #10-00-04, dated December 2014, located in the Responsive Behaviour section of the Resident Services Manual

A review of the above noted documents confirmed that there were not written approaches to care that included screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. There were not written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. There were not resident monitoring and internal reporting protocols. [s. 53. (1)]

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

Actions were not taken to assess responsive behaviours identified as being demonstrated by resident #103 and the resident's response to intervention put in place by direct care staff were not documented.

Data collected for resident #103 on a MDS review on an identified date in December 2015, indicated that the resident had a responsive behaviour four to six days out of seven and this behaviour was not easily altered. The following MDS review on an identified date in March 2016, indicated that the resident's responsive behaviour had worsened, were being demonstrated daily and this behaviour continued to be not easily altered. The resident's plan of care indicated in various places that the resident demonstrated responsive behaviours. During an interview with registered staff #056 on June 13 2015, it was confirmed that when a resident demonstrated a responsive behaviour PSW would enter a check mark in the computerized record to indicate that the resident exhibited resistance but they did not document the specific behaviour being demonstrated. A review of the computerized record for the 30 days preceding this inspection confirmed that PSWs had entered a check mark indicating the resident demonstrated resistive behaviours on seven days in May, and two days the first week of June 2016. Registered staff #056 also confirmed that if a registered staff member is aware of a responsive behaviour being demonstrated by a resident they would document the specifics of the behaviour on a customized progress note in the computerized record.

During the interview with registered staff #056 they reviewed the custom progress notes and confirmed that there had been no behavioural notes written for this resident. Registered staff #056 confirmed that there was not a tool used in the home where specific behavioural data could be collected, that the resident's response to interventions, in order to complete a behaviours assessment and that there was no evidence in the clinical record that resident #103's responsive behaviours had been assessed or the resident's response to staff's interventions had been documented. [s. 53. (4) (c)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee failed in the duty to consult regularly with the Residents' Council, at least every three months.

A review of the Residents' Council meeting minutes indicated that the council had not met over an eight month period of time between September 2015 and May 2016. The Chief Administrator Officer and previous council meeting minutes confirmed that the Volunteer Coordinator/Manager of Foundation had been appointed and accepted by the residents as the person designated to assist the Council. The assistant to Residents' Council confirmed that a Council meeting had not been held since August 2015, was unable to provide a reason for the lack of a Council meeting, that no action had been taken over the above noted eight month period of time to assist the Council in calling a meeting of the residents and during the eight month period of time no representative of the licensee had consulted with the Residents' Council.

Resident #300, who attended the August 2015, Council meeting was interviewed and indicated that they felt there had not been a council meeting because there were too many staff involved with assisting the Council, these people just kept changing and that they needed to have meetings more often so the meetings don't have to be so long. Resident #301, who attended the August 2015, Council meeting was interviewed and indicated that they were aware there was a long delay in having a council meeting, but they did not know why.

Resident #302, who attended the August 2015 Council meeting was interviewed and indicated they did not know why there were no meetings, they were never notified or told why there was such a delay, found it very frustrating because the person assigned to assist the Residents' Council kept changing and that they felt the Residents' Council was very important and they would like to see regular meetings scheduled. [s. 67.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (5) If any food or beverages are prepared in the long-term care home for persons who are not residents of the home, the licensee shall maintain, and keep for at least seven years, records that specify for each week,
(a) the number of meals prepared for persons who are not residents of the home; and O. Reg. 79/10, s. 72 (5).
(b) the revenue and internal recoveries made by the licensee relating to the sale or provision of any food and beverage prepared in the home, including revenue and internal recoveries made from cafeteria sales and catering. O. Reg. 79/10, s. 72 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that records were kept that specified for each week, the number of meals prepared for persons who were not residents of the home and the revenue and internal recoveries made by the licensee relating to the sale of food prepared in the home including from the cafeteria.

During a dining observation on May 25 and June 1, 2016, staff and visitors were observed to be provided meals from the resident servery towards the end of the resident meal service. In an interview with the Nutrition Manager on June 7, 2016, it was confirmed that this activity was a cafeteria function in this home.

An audit of the "Employee Meal Request" receipts was completed for May 2016, which identified a total of 115 dollars of revenue was made from the sales of food purchased from the cafeteria. A review of the "Monthly Raw Food Report" for May 2016, identified the total sales of food purchased from the cafeteria was 575 dollars. During a review of the "Employee Meal Request" receipts it was noted some receipts were not dated, did not identify amounts paid or what food was purchased.

During an interview with the Nutrition Manager on June 7, 2016, it was shared that home tracked the number of meals prepared and revenue made from cafeteria sales using the "Employee Meal Request" receipts. It was confirmed that "Employee Meal Request" records were incomplete and that there were no records that identified the total number of meals made or the revenue made from cafeteria sales for each week of May 2016. [s. 72. (5)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219(1) in the area of continence care and bowel management in accordance with O. Reg. 79/10, s. 221(1)3, in relation to the following: [76(7)6]

A review of the home's training records indicated that all registered staff received retraining in relation to continence care and bowel management. A review of the training records for PSW staff and an interview with the DOC indicated that the home only provided training in the area of the continence definitions in the Point of Care (POC) system; training regarding timeliness of documenting continence in the POC system and training in regards to the homes incontinent product protocol. The home was unable to provide retraining information provided to the PSW staff related to continence care and bowel management.

The DOC confirmed that the home had provided annual retraining in the area of continence care and bowel management to 33 percent of staff who provided direct care in 2015. [s. 76. (7) 6.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that payment was not accepted on behalf of a resident for anything that the licensee was prohibited from charging for under subsection (1) 4 and failed ensure they did not cause or permit anyone to make such a charge or accept a payment on the licensee's behalf.

During a family/designate interview on an identified date in May 2016, for resident #102 it was shared that resident #102's family/designate requested a specific care intervention to meet the resident's needs. In an interview with staff #059 on May 31, 2016 and with staff #035 and #075 on an identified date June 2016, it was confirmed that resident #102 required the requested intervention. Staff #035 confirmed that when resident #102 was provided the specific care intervention it was effective in meeting the residents care needs.

A review of the care plan identified resident #102 received the specific care intervention. An invoice on an identified date in 2016, identified resident #102 was charged for three of the specific care interventions provided which totalled a specific amount of dollars. In an interview with the DOC on June 1, 2016, it was confirmed that resident #102 was charged to receive the specialized care intervention at an identified rate of specific dollars after the "trial" period ended.
The following policy is part of the L-SAA agreement between a Local Health Integration Network and a Healthcare Service Provider who operates a Long-Term Care Home. The "LTCH Level of Care Per Diem Funding Policy", July 1, 2010, defines the nursing and personal care envelope to include expenditures for 1. a) staff provides personal care directly to the resident to meet the personal care requirements assessed in a care plan and b) personal care includes assistance with activities of daily living, including personal hygiene services. [s. 91. (4)]

Issued on this 2nd day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), CATHY FEDIASH (214), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2016_341583_0010
Log No. / Registre no:	015876-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 22, 2016
Licensee / Titulaire de permis :	FOYER RICHELIEU WELLAND 655 Tanguay Ave, WELLAND, ON, L3B-6A1
LTC Home / Foyer de SLD :	FOYER RICHELIEU WELLAND 655 TANGUAY AVENUE, WELLAND, ON, L3B-6A1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SEAN KEAYS

To FOYER RICHELIEU WELLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_248214_0021, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The Order is made based upon the application of the factors of severity (2 - risk or potential for actual harm), scope (2 - pattern) and compliance history (4 - ongoing non compliance with an order), and the Licensee's history of non-compliance with a CO on November 9, 2015 and a VPC on November 14, 2014.

The licensee shall ensure that the following is completed.

1. Ensure all residents experiencing pain, including residents #100 and #103 are reassessed and their plans of care are reviewed and revised as needed.

2. Resident #103 is reassessed to ensure that the incontinence product being provided for them is based on their assessed need and that their care plan is revised so front line staff provide the continence care products required to meet their needs. The home is to ensure that all residents who require incontinent products have been assessed and are being provided the products they require based on their assessed needs.

3. Resident #102's care plan is reviewed and revised to ensure all recommendations made by the Speech Language Pathologist (SLP) are included in the care plan for front line staff to follow. Educate front line staff on the specialized feeding strategies and interventions resident #102 requires. Complete visual audits to ensure the SLP recommendations are being followed.

4. Ensure there is an auditing process to ensure ongoing compliance with care plans being reviewed and revised when required per the legislation.

Grounds / Motifs :

1. 4. The licensee failed to ensure that residents were reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed.

A) Resident #100 was not reassessed and their care plan was not reviewed and revised when it was identified that the resident began to experience pain. Registered staff documented on a MDS review completed on an identified date in January 2016, that the resident experienced no pain and then documented on the following MDS review completed on an identified date in April 2016, that the resident had experienced pain less than daily at a mild level. Resident #100's clinical record indicated that the resident's physician ordered the resident to receive a specified amount of pain medication three times a day and a review of

the Medication Administration Records (MAR) indicated the resident received this medication through March, April and May 2016.

During an interview on June 2, 2016, the RAI Coordinator and the clinical record confirmed that the data collected on an identified date in April 2016, represented a change in the resident's condition, staff had not completed the RAI-MDS assessment when they did not complete a non-triggered Resident Assessment Protocol (RAP) related to pain and the clinical record did not contain a reassessment of the pain the resident experienced. The RAI Coordinator also confirmed that when it was identified that the resident experienced pain, the plan of care had not been reviewed or revised and at the time of this inspection there was not a care focus related to pain management in the resident's plan of care. (129)

B) Resident #103 was not reassessed and their care plan was not reviewed and revised when it was identified that the resident began to experience pain. Registered staff documented on a MDS review completed on an identified date in December 2015, that the resident experienced no pain and then documented on the following MDS review completed on an identified date in March 2016, that the resident had experienced pain less than daily at a moderate level. The resident's plan of care indicated the resident's physician had ordered the resident to receive a specified amount of pain relief medication twice a day and a review of the MAR indicated the resident received this medication through March, April and May 2016.

During an interview on June 2, 2016, the RAI Coordinator and the clinical record confirmed that the data collected on an identified date in March, 2016, represented a change in the resident's condition, staff did not complete the RAI-MDS assessment when they did not complete a non-triggered RAP related to pain and the clinical record did not contain a reassessment of the pain the resident experienced. The RAI Coordinator also confirmed that when it was identified that the resident experienced pain, the plan of care had not been reviewed or revised and at the time of this inspection there was not a care focus related to pain management in the resident's plan of care. (129)

C) During an interview with a family member of resident #103, it was communicated that the resident recently had a change in their incontinent product size as the previous product was too small. It was indicated that the current size was too large and there was no product in between.

An interview with staff #066 on June 1 2016, indicated that at the start of their shift the resident was wearing a large/extra-large incontinent product and that following their bath later on the same day, the resident was wearing a medium/regular sized incontinent product. Staff #066 confirmed that the size of incontinent product was too small causing product lines to be noted on the resident's skin. An interview with staff #036 on June 1, 2016, confirmed that the medium/regular sized incontinent product was noted to be too small approximately three weeks – one month ago and that the current large/extra-large product was too big.

An interview with the RAI Coordinator who managed the continence program and staff #032 who was a member of the home's continence program indicated that the home used an assessment titled, "TENA Portraits- Quick Reference Guide" to determine the type of product to be used and that the resident's weight was used to determine the size of the product. It was indicated that if the resident weighed 185 pounds or less, they were to use the medium/regular size and if they weighed more than 185 pounds, they were to use the large/extra-large size. Staff #032 indicated that the most current assessment completed for the resident was in December 2015 and indicated that the resident was assessed to use the medium/regular size product. The RAI Coordinator and staff #032 confirmed that a referral had not been received from staff to reassess the resident's incontinent product. A telephone interview with the incontinent product representative on June 7, 2016, indicated that using weight alone was an informal guide for measuring and usually done on admission and that sizing which involved measuring the waist and hips was then to be conducted. A review of the resident's current written plan of care indicated under bladder and bowel incontinence with an identified initiated date in February 2014, that the resident was to wear a medium sized incontinent product.

The RAI Coordinator confirmed that the resident was not reassessed and their plan of care was not reviewed and revised when their care needs related to their type and size of incontinent product had changed. The RAI Coordinator confirmed that the resident had now been reassessed and a new incontinent product had been implemented on a trial basis. (214)

D) A review of the home's "concern or complaint investigation form" documented on an identified date in May 2016, identified resident #102's family notified the DOC that they were concerned direct care staff were not following

recommendations put in place registered staff.

On an identified date in June 2016, Long Term Care (LTC) Inspector #583 observed staff #035 feeding resident #102 in the dining room during lunch service. LTC Inspector #583 observed staff feeding the resident and identified two of the swallowing recommendations were not being followed. In an interview with the with staff #035 it was identified that they were not aware of these two recommendations.

A progress note documented on an identified date in November 2015, by staff #053 identified resident #102's family brought forward a concern that they observed staff not following the recommendations.

A review of resident 102's plan of care identified they were at high nutrition risk and were referred to SLP for feeding and swallowing problems. The resident was assessed by the registered staff on an identified date in November 2015, and several recommendations were made.

Resident #102's progress notes were reviewed for an identified time period in 2016. It was documented five times over the identified time period that resident #102 displayed swallowing difficulties related to eating.

Resident #102's eating focus care plan was reviewed and it was identified that the eating and feeding recommendations had not be added and that the care plan was last revised on an identified date in October 2015. In an interview with staff #053 on June 1 2016, it was confirmed that eating care plan interventions were not revised when resident #102's care needs changed. [s. 6. (10) (b)] (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The Order is made based upon the application of the factors of severity (2), scope (3) and compliance history (2), in keeping with s.299 (1) of the Regulation, in respect to the potential for actual harm to a large number of residents and a widespread scope when 100 percent of residents residing in the home had not been assessed for the safe use of bed rails; five of five bed systems identified that had bed components changed had not been reassessed for safety and seven of seven bed systems identified by Inspectors as having potential bed system safety concerns had not had those safety concerns addressed.

The licensee shall prepare, submit and implement a plan to ensure that when bed rails are used the resident and their bed system is evaluated to minimize risk to the resident and where risk has been identified, steps are taken to prevent resident entrapment. The plan is to include but is not limited to the following:

1. The development of an interdisciplinary resident assessment to be used to assess all resident who have care directions for the use of bed rails. The assessment tool is to be based on the guidance document "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", April 2003, developed by the Hospital

Bed Safety Workgroup.

2. The development and implementation of a schedule for the interdisciplinary assessment of all residents who use one or more bed rails using the assessment tool noted above and document the assessment results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified following the assessment. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

4. The development and implementation of a system and schedule for monitoring compliance with the assessment and reassessment of residents related to the use of bed rails.

5. The initiation and documentation of an interdisciplinary mattress audit indicating which beds have mattresses that easily slide from side to side on the bed deck of the bed while the bed rails are down or in the transfer position. Where it has been determined that there is lateral movement of the mattresses on the bed decks, those mattresses are to be secured.

6. The development and implementation of a bed safety education program for staff who provide care to residents and for staff who are responsible for auditing bed safety. The education program at a minimum shall include information related to the risks associated with the use of bed rails, alternatives to the use of bed rails, when and under what circumstances bed rails will be used in the home, how to recognize when a bed system is unsafe, how and when to report bed safety concerns, communication systems to be implemented when a bed system component is altered or not functioning and how to apply any entrapment zone interventions if necessary.

The plan is to be submitted on or before August 31, 2016, to Kelly Hayes at Phyllis.HiltzBontje@ontario.ca

Grounds / Motifs :

1. 4. The licensee failed to ensure that residents were reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed.

A) Resident #100 was not reassessed and their care plan was not reviewed and revised when it was identified that the resident began to experience pain. Registered staff documented on a MDS review completed on an identified date in January 2016, that the resident experienced no pain and then documented on the following MDS review completed on an identified date in April 2016, that the resident had experienced pain less than daily at a mild level. Resident #100's clinical record indicated that the resident's physician ordered the resident to receive a specified amount of pain medication three times a day and a review of the Medication Administration Records (MAR) indicated the resident received this medication through March, April and May 2016.

During an interview on June 2, 2016, the RAI Coordinator and the clinical record confirmed that the data collected on an identified date in April 2016, represented a change in the resident's condition, staff had not completed the RAI-MDS assessment when they did not complete a non-triggered Resident Assessment Protocol (RAP) related to pain and the clinical record did not contain a reassessment of the pain the resident experienced. The RAI Coordinator also confirmed that when it was identified that the resident experienced pain, the plan of care had not been reviewed or revised and at the time of this inspection there was not a care focus related to pain management in the resident's plan of care. (129)

B) Resident #103 was not reassessed and their care plan was not reviewed and revised when it was identified that the resident began to experience pain. Registered staff documented on a MDS review completed on an identified date in December 2015, that the resident experienced no pain and then documented on the following MDS review completed on an identified date in March 2016, that the resident had experienced pain less than daily at a moderate level. The resident's plan of care indicated the resident's physician had ordered the resident to receive a specified amount of pain relief medication twice a day and a review of the MAR indicated the resident received this medication through March, April and May 2016.

During an interview on June 2, 2016, the RAI Coordinator and the clinical record confirmed that the data collected on an identified date in March, 2016, represented a change in the resident's condition, staff did not complete the RAI-MDS assessment when they did not complete a non-triggered RAP related to pain and the clinical record did not contain a reassessment of the pain the

resident experienced. The RAI Coordinator also confirmed that when it was identified that the resident experienced pain, the plan of care had not been reviewed or revised and at the time of this inspection there was not a care focus related to pain management in the resident's plan of care. (129)

C) During an interview with a family member of resident #103, it was communicated that the resident recently had a change in their incontinent product size as the previous product was too small. It was indicated that the current size was too large and there was no product in between.

An interview with staff #066 on June 1 2016, indicated that at the start of their shift the resident was wearing a large/extra-large incontinent product and that following their bath later on the same day, the resident was wearing a medium/regular sized incontinent product. Staff #066 confirmed that the size of incontinent product was too small causing product lines to be noted on the resident's skin. An interview with staff #036 on June 1, 2016, confirmed that the medium/regular sized incontinent product was noted to be too small approximately three weeks – one month ago and that the current large/extra-large product was too big.

An interview with the RAI Coordinator who managed the continence program and staff #032 who was a member of the home's continence program indicated that the home used an assessment titled, "TENA Portraits- Quick Reference Guide" to determine the type of product to be used and that the resident's weight was used to determine the size of the product. It was indicated that if the resident weighed 185 pounds or less, they were to use the medium/regular size and if they weighed more than 185 pounds, they were to use the large/extra-large size. Staff #032 indicated that the most current assessment completed for the resident was in December 2015 and indicated that the resident was assessed to use the medium/regular size product. The RAI Coordinator and staff #032 confirmed that a referral had not been received from staff to reassess the resident's incontinent product. A telephone interview with the incontinent product representative on June 7, 2016, indicated that using weight alone was an informal guide for measuring and usually done on admission and that sizing which involved measuring the waist and hips was then to be conducted. A review of the resident's current written plan of care indicated under bladder and bowel incontinence with an identified initiated date in February 2014, that the resident was to wear a medium sized incontinent product.

The RAI Coordinator confirmed that the resident was not reassessed and their plan of care was not reviewed and revised when their care needs related to their type and size of incontinent product had changed. The RAI Coordinator confirmed that the resident had now been reassessed and a new incontinent product had been implemented on a trial basis. (214)

D) A review of the home's "concern or complaint investigation form" documented on an identified date in May 2016, identified resident #102's family notified the DOC that they were concerned direct care staff were not following recommendations put in place registered staff.

On an identified date in June 2016, Long Term Care (LTC) Inspector #583 observed staff #035 feeding resident #102 in the dining room during lunch service. LTC Inspector #583 observed staff feeding the resident and identified two of the swallowing recommendations were not being followed. In an interview with the with staff #035 it was identified that they were not aware of these two recommendations.

A progress note documented on an identified date in November 2015, by staff #053 identified resident #102's family brought forward a concern that they observed staff not following the recommendations.

A review of resident 102's plan of care identified they were at high nutrition risk and were referred to SLP for feeding and swallowing problems. The resident was assessed by the SLP on an identified date in November 2015, and several recommendations were made.

Resident #102's progress notes were reviewed for an identified time period in 2016. It was documented five times over the identified time period that resident #102 displayed swallowing difficulties related to eating.

Resident #102's eating focus care plan was reviewed and it was identified that the eating and feeding recommendations had not be added and that the care plan was last revised on an identified date in October 2015. In an interview with staff #053 on June 1 2016, it was confirmed that eating care plan interventions were not revised when resident #102's care needs changed. [s. 6. (10) (b)] (129)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of July, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

Service Area Office /
Bureau régional de services : Hamilton Service Area Office