Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2017	2017_491647_0013	011666-17	Resident Quality Inspection

Licensee/Titulaire de permis

HILLCREST VILLAGE INC.
255 RUSSELL STREET MIDLAND ON L4R 5L6

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

HILLCREST VILLAGE CARE CENTRE
255 RUSSELL STREET MIDLAND ON L4R 5L6

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

JENNIFER BROWN (647), CECILIA FULTON (618), DIANE BROWN (110), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, July 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 2017.

The following critical incidents were inspected concurrently with this inspection:
011594-16
024849-16
025948-16
030039-16

032069-16
033630-16
035316-16
034876-16
002527-17
002734-17
003718-17
005550-17
006335-17
011170-17

The following complaints were inspected concurrently with this inspection:
007965-17

The following follow-ups to previously issued compliance orders were inspected concurrently with this inspection:
004400-17

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Environmental Services Manager (ESM), Resident Care Facilitator (RCF), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Coordinator, Restorative Care Nurse, Program Coordinator, Restorative Therapy Service Coordinator, Recreation Program Assistant, Housekeeping and Laundry Supervisor, Personal Support Workers (PSW), Health Care Aides (HCA), Housekeeping, Receptionist/Nursing Clerk, Psychogeriatric Resource Consultant, Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observations in the home and resident home areas, observations of care delivery processes including medication administration and meal delivery services, review of the home's policies and procedures, and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **12 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_268604_0020	647
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2016_268604_0020	110

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 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.

A Critical Incident System Report, dated and reported to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2017, identified resident #042 exhibiting a responsive behaviour towards resident #041.

A review of the progress notes for resident #042 during an identified period of time, indicated there were six instances of responsive behaviour.

A review of the most current written plan of care to the incident, revealed resident #042 experienced responsive behaviour toward others. Triggers and interventions for behaviours of responsive behaviour toward others were not identified in the written plan of care.

An interview with direct care staff member #144 and Registered staff member #134 revealed resident #042 had responsive behaviour with residents and on an identified date in 2017, demonstrated a responsive behaviour to resident #041 causing a slight injury. Specific interventions for responsive behaviour, other than removal from the situation, were not identified on the written plan of care.

An interview with the Director of Care (DOC) confirmed that the written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

The MOHLTC ACTIONline had been contacted on an identified date in 2017, by the family member of resident #026 indicating that resident #026 had complained that the way he/she receives assistance for an activity of daily living caused discomfort.

An interview with the complainant indicated that resident #026 tends to avoid this activity of daily living because he/she experiences pain.

During an interview with resident #026, he/she acknowledged that the current intervention to complete the identified activity of daily living caused pain. Resident #026 indicated that he/she prefers to avoid this activity however indicated that if there was a more comfortable intervention to complete this identified activity of daily living, then he/she would wish to receive that.

Interviews with direct care staff member #128 and Registered staff member #104 acknowledged that resident #026 has voiced to the staff that the identified activity of daily

living caused pain.

Interview with Restorative Therapy Service Coordinator (RTSC) indicated that the home has a contracted service provider to assist with the identified activity of daily living. The RTSC further indicated that the preferred vendor is available to support the home in education, support and working collaboratively in ensuring residents' needs are met.

An interview with the Assistant Director of Care (ADOC) indicated that the expectation of the home is to work collaboratively with all care partners to ensure the needs of all residents are met.

The ADOC further confirmed that there had not been care collaboration between the homes' staff, resident, resident's family and/or the home's contracted service provider to ensure resident #026 received additional assessments to complete the identified activity of daily living that did not cause discomfort to resident. [s. 6. (4) (a)]

3. The MOHLTC ACTIONline had been contacted on an identified day in 2017, by a family member of resident #026 to indicate that resident #026 had unresolved skin integrity issues.

During an interview with the complainant revealed that resident #026 has had a history of altered skin integrity.

During an interview with resident #026, he/she acknowledged his/her history and skin condition. Resident #026 indicated that he/she had tried several medications since admission in 2016, and there had not been any change in symptoms.

Interviews with direct care staff member #128 and Registered staff member #104 acknowledged that resident #026 has had unresolved skin issues since admission and often had been frustrated at the unsuccessful attempts to relieve the symptoms.

A clinical chart review indicated that the physician had written an order for a dermatology referral on an identified date in 2017. A further clinical chart review indicated that the home had not sent the referral until several weeks after. On a later identified date in 2017, the dermatology referral faxed a reply to the home stating they could not see resident #026 as they have experienced a large number of referrals and suggested the home use another service provider. At the time of inspection, this suggestion had remained unprocessed.

An interview with the ADOC indicated that the expectation of the home is to work timely and collaboratively with all care partners to ensure the needs of all residents are met.

The ADOC further confirmed that there had not been care collaboration between the homes' staff, resident, resident's family and/or the dermatology consultation in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

4. Resident #003 was triggered during stage 1 of the Resident Quality Inspection (RQI) related to a fall.

Record review identified that resident #003 was found sitting on the floor beside his/her bed at an identified time and date in 2017.

Interview with Registered staff #104 who responded to the fall confirmed that the home considered resident #003 unintentional position on the floor as a fall and staff were to complete a post fall assessment.

Registered staff #104 further identified that a post fall huddle is completed to review interventions and that the form is forwarded to Resident Care Facilitator (RCF) to review the plan of care, summarize factors contributing to the fall and identify the action plan as a collaborative approach to a fall assessment.

Record review of the written plan of care revealed no changes made related to resident's fall.

Review of the resident's health record identified a Post Fall Assessment dated on the identified date 2017 completed by Registered staff member #104. Review of the assessment identified it was incomplete with no documentation of a post fall huddle, summary of factors contributing to the fall, review of the care plan by the RCF or actions taken.

Interview with ADOC and RCF confirmed that form was incomplete, must have been filed before reviewed by the RCF and that staff did not collaborate in the fall assessment as required. [s. 6. (4) (a)]

5. The home contacted the MOHLTC after hours pager on an identified date in 2016, and

subsequently submitted a Critical Incident Report, which had indicated that there had been an incident of responsive behaviour from resident #052 towards co-resident #042.

A review of the above mentioned CIS indicated that resident #052 had been observed to be in resident #042's room exhibiting a responsive behaviour and resident #042 had been observed to have an injury.

A record review indicated that resident #052 had been admitted on an identified date in 2016, with cognitive impairment. A further record review indicated that resident had frequently displayed responsive behaviours towards staff.

A record review of the discharge note from the behavioural support specialist, indicated the recommendation that the home was to complete a further assessment that would allow for data collection to identify whether the responsive behaviours had increased or worsened in frequency and severity.

A record review of the above mentioned Cohen Mansfield Agitation Inventory indicated it had been completed by the home and resulted in an identified score.

Interviews with Registered staff members #138 and #137 acknowledged that there had not been any explanation of the Cohen Mansfield Agitation Inventory and were not aware what the score indicated. The above mentioned staff further indicated that because there had not been collaboration with the Behavioural Intervention Response Team (BIRT), the home had been unable to identify whether the responsive behaviours had increased or worsened in frequency and severity.

An interview with the DOC indicated that the expectation of the home is to have followed up with the BIRT team to gain an understanding and interpret the results from the Cohen Mansfield Agitation Inventory.

The DOC further confirmed that as a result of not collaborating with the BIRT team relating to the results of the above mentioned agitation inventory, there had not been care collaboration between the homes' staff and the BIRT team in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

6. Review of a CI, identified that resident #010 had a fall resulting in an injury on an identified date.

Record review of the progress notes on an identified date, identified that resident #010 fell while he/she was in his/her room, fell and injured an identified area.

Interview with direct care staff member #146 who responded to the resident's fall, confirmed that the resident stated he/she lost his/her balance.

Resident #010 was not in the home, at the time of the inspection to be interviewed.

Interviews with restorative care nurse and ADOC identified the home has interdisciplinary team meetings three days per week whereby residents who had fallen are discussed by department heads, RCF's and restorative care with interventions identified.

A review of the Daily Interdisciplinary Meeting Minutes for an identified period of time, identified resident #010's fall with the following intervention:
Staff members to assist resident in room to avoid falls.

Record review of the resident's plan of care failed to identify the intervention.

Interview with the Program coordinator #148, in attendance at the identified meeting, unable to confirm if all staff were informed of the intervention.

Interviews with program staff #150 and direct care staff member #146 confirmed a lack of awareness of the intervention to provide assistance for the next month for resident to avoid falls.

Interview with RCF identified that he/she should have entered the intervention into Point of Care (POC) as a task and it was missed.

Interview with ADOC confirmed there was a lack of collaboration between staff in the fall prevention intervention identified for resident #010 following his/her fall on an identified date in 2016. [s. 6. (4) (a)]

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

A CIS dated on an identified date in 2016, and further reported to the MOH, identified resident #036 was discovered by Registered staff member #147 to be in a compromised

position between the side rail and the mattress.

The written plan of care most current to the incident, revealed that no side rails were to be used.

An interview with direct care staff member #136 and Registered staff member #147 revealed resident #036 was found compromised between the side rail and the mattress. They revealed the current written plan of care most current to the incident, revealed that no side rails were to be used.

An interview with the ADOC revealed that no side rails were to be used, therefore the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

8. A CI, for an identified date in 2017, and further reported to the MOH, identified resident #039 demonstrated a responsive behaviours to resident #040 in an identified area prior to the identified meal.

The most current written plan of care to the incident, revealed resident #039 demonstrated responsive behaviours and was to wear an identified intervention, on an identified date.

An observation during the inspection by Inspector #519 and Registered staff member #134 revealed the resident was not wearing the identified intervention.

A record review of the progress notes revealed the above mentioned responsive behaviour on six occasions during an identified period of time.

An interview with direct care staff member #132 and Registered staff member #134 identified responsive behaviour for resident #039.

An interview with ADOC confirmed the expectation of the home was that the written plan of care should be followed and provided to the resident as specified in the plan. [s. 6. (7)]

9. The home contacted the MOHLTC after hours pager on an identified date in 2016, and subsequently submitted a CIS, which had indicated that there had been an incident of responsive behaviour from resident #052 towards co-resident #042.

A review of the above mentioned CIS indicated that resident #052 had been observed to be in resident #042's room demonstrating a responsive behaviour and resident #042 had been observed to have an injury.

A record review indicated that resident #052 had been admitted in 2016, with cognitive impairment. A further record review between an identified period of time, indicated that resident had frequently demonstrated responsive behaviors towards staff.

The home initiated a Dementia Observation System (DOS) to observe resident #052's behaviors. A review of the DOS records from an identified period of time indicated that there had been no observation of residents' behaviors documented on 77 shifts during the day shift, on 46 shifts during the evening shift and on 37 shifts during the night shift.

Interviews with direct care staff member #138 and Registered staff members #138 and #137 indicated that all staff are to document on the DOS record as the information would then be collected and analyzed to identify possible triggers and to strategize on interventions and patterns for the exhibited behaviors.

An interview with the DOC confirmed the use of the DOS tool as a way to trend the data of the behaviors and collaborate with staff and external partners to establish interventions to manage the responsive behaviors of resident #052. The DOC acknowledged during the interview that staff had not documented the behaviors of resident #052 on the shifts mentioned above and therefore had not provided the care set out in the plan of care for resident #052 as specified in the plan. [s. 6. (7)]

10. The licensee has failed to 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 the care set out in the plan has not been effective.

Review of CI identified that resident #010 had a fall resulting in injury on an identified date in 2016. Further review of the CI identified resident experienced four falls within the last six months while resident has been doing an activity of daily living in his/her room.

A review of the resident's plan of care identified a fall prevention intervention on an identified date, that there would be an adjustment to an identified item in resident's room to prevent further falls.

Observation of resident #010's with direct care staff member #101 on an identified date,

confirmed that the adjustment to the identified item in resident's room to prevent further falls had not been completed.

Interview with the ADOC identified that staff had not reviewed and revised resident #010's plan of care related to falls prevention at least every six months as staff would have identified that the adjustment to the identified item in resident's room had not be been completed. [s. 6. (10) (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 involve staff and others in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to 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 the care set out in the plan has not been effective and to ensure that the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, and different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The medication inspection protocol had been completed during the resident quality inspection.

A record review of the medication incident reports from an identified period of time, had indicated there had been 32 medication related incidents for the above mentioned time frame.

A further record review of the above mentioned medication incidents indicated:

An identified month in 2017: three dose omissions, one extra dose, two incorrect medications administered, two incorrect strength, and two incorrect times of administration,

An identified month in 2017: two dose omissions, two extra doses, one incorrect dose, and three incorrect medications administered,

An identified month in 2017: nine drug omissions, one incorrect resident, one incorrect strength, and three incorrect times of administration.

A review of the medication incident reports titled medication/incident counseling/coaching checklist with corrective action plan, from the dates indicated above, indicated that the corrective action plan had not been completed for the 32 medication incidents mentioned above.

Record review of the home's policy titled "Medication Incident Policy and Procedure" revised January 29, 2015, indicated the following under procedure:

"Once the report is received from Pharmacy the RCF will be responsible to initiate corrective action. The DOC will oversee process and monitor Incidents for Quality Assurance".

During an interview, the DOC stated that the home's expectation was for the RCF to initiate corrective action. The DOC acknowledged that the home's policy on medication incidents was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with: 1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

During the course of the inspection several observations were made of doors leading to identified areas within two buildings within the home.

On an identified date and time during the inspection, the door to an identified home area was found unlocked and unsupervised. Inspector #618 opened the door and waited for several minutes to see if there was any audible alarm, or if a staff member would come to investigate the open door. Direct care staff member #140 observed what was happening and stated that the door would trigger an alarm on the staff pagers and at the nursing station. Direct care staff member #140 went to see if that was happening and returned to tell the inspector that nothing was alarming.

On an identified date and time during the inspection, the door to an identified home area was found unlocked and unsupervised. Inspector #618 opened the door and accessed the identified area and waited several minutes and no staff came.

On this same unit a door from an identified room to the identified area was found to be unlocked and unsupervised. Inspector #618 opened the door and waited to see what would happen. The inspector observed a scrolling electronic message in the nursing station indicating that the identified door had been opened. No staff were in the area to observe this sign or the door and no staff attended to the door.

On an identified date and time during the inspection, the door to an identified home area was found unlocked and unsupervised and the identified area was accessible to residents.

On an identified date and time, three residents were observed sitting on an identified home area, and several more residents were in the activity room adjacent to the identified area. The door was not locked or supervised.

Observations made on an identified date and time, revealed all these same doors as mentioned above to be unlocked and unsupervised, although no residents were on the identified area or in the adjacent lounge.

Interview with Registered staff member #104 revealed that this door is left unlocked to facilitate resident access to the identified area. Registered staff member #104 was not aware if there was any supervision of the door.

Regarding the door on the identified area, an interview with the Environmental Services Manager (ESM) confirmed that this door is left unlocked to facilitate resident access to the balcony.

On an identified date and time during the inspection, the door to an identified home area was once again found unlocked and unsupervised. When Inspector #618 opened the door and waited no one attended to the door. After several minutes Registered staff member #140 saw the inspector and confirmed that an alarm was supposed to be triggering on the staff pagers, but it was not.

Interview and observation made shortly after this with the ESM revealed that a lock block had been put on this door and he/she stated that there was a malfunction of the sensor which he/she had called the company about.

Interview and observation made with the ESM on an identified date and time, revealed the door on the identified home area to be unlocked and unsupervised. As before, when the door was opened the scrolling message ran at the nursing station, however no one was in the area to observe the message. The ESM confirmed that the message was not coming through on the staff pagers.

Direct care staff member #159 revealed that there are two resident's residing on the unit that have responsive behaviours. [s. 9. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rules are complied with: 1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. Review of a CIS identified that resident #010 had a fall resulting in injury on an identified date. Further review of the CIS identified resident with a history of falls and had four falls during an identified time period.

A review of the resident's plan of care identified a fall prevention intervention on an identified date, was to be implemented.

Observation of resident #010's room with direct care staff member #101 on an identified date, confirmed the intervention mentioned above had not been implemented.

Interview with restorative care nurse #147 confirmed that the process when a maintenance request was required was to enter the request into an electronic referral system called 'TheWorxHub". Further interview identified that Restorative Care Nurse #147 was unaware that the requested intervention had not been completed as requested.

Record review confirmed a TheWorxHub request form completed on the identified date, by restorative care nurse #147 for resident #010's room. The request identified resident #010's room with details related to the fall prevention strategy, due to previous multiple falls.

Interview with maintenance supervisor stated that he/she recalled the request and discussion, that they had found an alternative intervention however it never got implemented. The supervisor was unable to demonstrate documentation around the request and follow-up.

The maintenance supervisor confirmed that the maintenance program should be organized to acknowledge when and if requests have been completed. [s. 15. (1) (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 there is an organized program of maintenance services for the home, to be implemented voluntarily.

WN #5: 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. The licensee has failed to ensure that where bed rails are used, the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

A CIS dated on an identified date, and further reported to the MOH, identified resident #036 was discovered by Registered staff member #147 to have been in a compromised position while in bed with side rails raised.

An interview with direct care staff member #136 and Registered staff member #147 revealed resident #036's been in a compromised position while in bed with bed rails raised.

A review of the Bed System Measurement Device Test Results Worksheet for two identified years, revealed there were no results for one of the two years.

An interview with the ADOC confirmed the bed system for resident #036 had not been undertaken in one of the identified years following the identified incident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

The home submitted a CIS on an identified date, indicating that there had been an incident which involved resident #027 falling during a transfer.

A review of the above mentioned CIS indicated that during a transfer of resident #027 using a full mechanical lift, the resident fell to the floor. The CIS indicated that resident #027 sustained an injury.

A review of resident #027's plan of care identified the resident as dependent and required assistance from two staff for all transfers.

An interview with direct care staff member #122 indicated that on the identified date, he/she had been working with direct care staff member #125 and they had transferred resident #027. Direct care staff member #122 indicated that during the transfer of resident #027, and while both staff were assisting resident, the resident's body changed condition and resident #027 had landed on the floor.

Interviews with the RTSC indicated that lift and transfer training for all staff occurs annually and upon hire with the direction on how to safely transfer residents.

The DOC acknowledged the above mentioned incident that had taken place, where resident #027 had fallen during a transfer. The DOC confirmed during an interview that resident #027 had not been provided a safe transfer from staff on the identified date. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #7: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #006 triggered during stage one of the RQI related to continence.

Record review of the admission Minimum Data Set (MDS) for continence, identified resident #006 as occasionally incontinent. The following MDS quarterly review for continence, identified resident #006 as frequently incontinent. A review of the resident's health record failed to identify a continence assessment with this identified change in continence.

Interview with RAI coordinator revealed that when a resident has had a change in continence that a continence assessment form is used as the clinically appropriate assessment instrument which is specifically designed for assessment of continence.

An interview with direct care staff member #154 stated he/she thought the resident might have had a change in continence since admission but revealed that he/she did not think he/she was frequently incontinent as he/she had never had to change his/her product.

The RAI coordinator confirmed that resident's had a continence decline during the identified period of time, would have warranted the required assessments.

A review of the homes policy entitled Bowel and Bladder Management Program, Revised

Date: May 18, 2016, identified that Registered Nursing Staff are responsible to complete a Bowel and Bladder assessment quarterly if bowel or bladder changes are identified.

Interview with RAI coordinator confirmed that the home did not complete a continence assessment using a clinically appropriate assessment instrument when resident #006's continence declined. [s. 51. (2) (a)]

2. Resident #007 triggered during stage one of the RQI related to a continence decline.

Record review of resident #007's readmission MDS for continence, identified resident #007 as continent. The following MDS quarterly review for continence, identified resident #006 as occasionally incontinent.

Interview with RAI coordinator revealed that when a resident has had a change in continence that a Bladder and Bowel Continence assessment form is used as the clinically appropriate assessment instrument which is specifically designed for assessment of incontinence.

A review of the resident's health record failed to identify a continence assessment with his/her identified change in continence.

The RAI coordinator confirmed that resident #007 had a continence decline during the identified period of time, requiring staff to complete a continence assessment.

A review of the home’s policy entitled Bowel and Bladder Management Program, Revised Date: May 18, 2016, identified that Registered Nursing Staff are responsible to complete a Bowel and Bladder assessment quarterly if bowel or bladder changes are identified.

Interview with RAI coordinator and RCF #106 confirmed that the home did not complete a continence assessment using a clinically appropriate assessment instrument when resident #007's continence declined. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent received an assessment that:
includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

A CIS, for an identified date, and further reported to the MOH, identified resident #039 demonstrating a responsive behaviour towards resident #040.

A review of the progress notes for resident #039 revealed from an identified period of time, there were ten instances of responsive behaviour.

A review of resident #39's most current written plan of care to the incident, revealed, "recent responsive behaviours towards others. The written plan of care did not identify steps to take to minimize the above mentioned responsive behaviours.

An interview with direct care staff member #132 and Registered staff member #134 revealed resident #039 had demonstrated responsive behaviours with residents and on an identified day, demonstrated responsive behaviours towards resident #040 causing him/her to fall to the floor without injury.

An interview with ADOC confirmed that steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors that could potentially trigger altercations; and identifying and implementing interventions. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.

Resident #003 was triggered during stage one of the RQI for weight loss.

Record review revealed that on an identified date, the resident weighed an identified weight. This weight triggered the following weight change.
Weight loss of an identified number of kg's representing a 6 per cent weight loss over 30 days.
Weight loss of an identified number of kg's representing an 11.9 per cent weight loss over six months.

In addition, a record review revealed that on an identified date, the resident weighed an identified amount.
Weight loss of an identified number of kg's representing a 13.5 per cent weight loss over six months.

Review of the home's policy for the Nursing Department, entitled Weight Policy and Procedure, revised date: December 11, 2015, identified if a significant weight gain or loss

was noted, the RCF is responsible:
i. to complete a dietary referral, highlighting the area of concern;
ii. Complete a progress note in the Residents electronic chart regarding the findings and the required follow up for the concern.

An interview with staff member #139 revealed that the resident sometimes requests smaller portions and was changed diet textures just over a month ago. Interview with direct care staff member #142 revealed that at breakfast he/she is independent but by dinner he/she requires assistance. Both PSW staff were unaware if resident #003 had lost weight.

Interview with Registered Dietician (RD) #001 and #002 identified that nursing staff initiate a referral to the RD when residents experience significant weight changes and that within the referral, nursing staff document their assessment of the weight change for an interdisciplinary approach.

Interview with Registered staff member #143 revealed that whoever enters the weights into PCC should notify the RCF and either the registered staff or RCF complete a referral to the RD with the assessment of the weight change. Registered staff member #143 confirmed that nursing had not completed a referral for resident's weight loss in the identified period of time.

Interview with ADOC confirmed that there was no weight change assessment note or dietary referral initiated by nursing when resident #003 experienced a significant weight loss, and that weight changes were not assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The home submitted a CIS on an identified date, which identified that resident #012 had become compromised as a result of being served a food item that was to be avoided.

Record review of the resident's health record, progress notes, revealed that on an identified date, resident #012 was participating in a food program and had been served an identified food. Record review revealed that resident had an identified episode.

Record review of resident #012's plan of care identified that since his/her admission on the identified date, the resident's diet was regular and stated preferences of food choices.

Resident interview confirmed that he/she had told the home that he/she was not to have an identified food. The resident also confirmed that he/she was served this identified item at the food program and became compromised.

Staff interviews with recreation program assistants (RPA) #152, #153 and #150 identified that they had used a Diet Type Report which included the resident's name, diet type, texture and fluid consistency when serving meals at program events. The information available did not include the special instruction of the above mentioned identified food.

The RD and Food Service Manager (FSM) confirmed a process to ensure program staff assisting residents were aware of the residents diets, special needs and preferences was not in place for program staff at the time of resident #012's identified incident. [s. 73. (1) 5.]

2. The licensee has failed to ensure that proper techniques used to assist residents with eating, including safe positioning of residents who require assistance.

During the initial meal observation, direct care staff member #160 was observed sitting on a high unadjustable wood stool, as least two feet above resident # 014 while assisting to feed. The staff member was not at eye level with the resident and the resident's head was flexed upwards towards the staff.

Record review identified resident #014 at high nutritional risk.

Interview with direct care staff member #160 identified that he/she was sitting in an uncomfortable feeding position while assisting the resident and was unable to sit at eye level as expected with the high wooden stool.

Interview with Registered staff member #164 supervising the meal service revealed that some of the stools in the dining room were too high, allowing the staff to tower over

residents. Registered staff member #164 identified that staff should be sitting at eye level while assisting residents with their meals.

Record review of the home's inservice material entitled "The Positive Dining Experience and Feeding Assistance"-provided to inspector by the DOC included a section on how should the person assisting be positioned. The material identified the person assisting should be at eye-level with the resident; seated position beside the resident, feed assistance person should be comfortable; do not feed from above the mouth.

An interview with RD #1 confirmed that resident #014 was at increased risk, and required a modified diet to decrease the risk. The RD identified proper feeding techniques to minimize risk included staff to sit, eye to eye or even lower then resident's eye level.

The RD confirmed that proper feeding techniques were not used when feeding resident #014. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences and to ensure that proper techniques used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The medication inspection protocol had been completed during the RQI.

A record review of the medication incident reports from a three month period of time, had indicated there had been 19 medication incidents.

A further record review of the above mentioned medication incidents indicated:

March 2017: resident's #003, #031, #032, #048, #051 and #054 did not receive medications as prescribed,
April 2017: resident's #001, #035 and #053 did not receive medications as prescribed,
May 2017: resident's #030, #033, #035, #047, #049, #050 and #052 did not receive medications as prescribed,

The DOC acknowledged during an interview that the above mentioned residents had not received the above mentioned medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

The medication inspection protocol had been completed during the RQI.

A record review of the medication incident reports from a three month period of time, had indicated there had been 19 medication incidents.

A further record review of the above mentioned medication incidents indicated:

March 2017: resident's #003, #031, #032, #048, #051 and #054 did not receive medications as prescribed,
April 2017: resident's #001, #035 and #053 did not receive medications as prescribed,
May 2017: resident's #030, #033, #035, #047, #049, #050 and #052 did not receive medications as prescribed,

A review of the medication incident reports titled medication/incident counseling/coaching checklist with corrective action plan, from the dates indicated above, indicated that the corrective action plan had not been completed for the 19 medication incidents mentioned above.

An interview with the DOC acknowledged that page two of the above mentioned incident form was expected to be completed by the home and further confirmed that it had not been completed to include the corrective action to prevent re-occurrence, need for further investigation and re-evaluation of the medication system and a follow up date to review. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour program being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

A CIS dated on an identified date and further reported to the MOH, identified resident #039 demonstrated a responsive behaviour towards resident #040.

It is a legislative requirement that the Responsive Behaviour program be evaluated annually. A review of the Responsive Behaviour program revealed a policy for responsive behaviours, revised May 29, 2017.

An interview with the DOC revealed no previous evaluation had been completed in prior years. The DOC confirmed that an evaluation of the responsive behavior program had not occurred. [s. 53. (3) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure when making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident, in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident.

Review of CI dated for an identified date, reported an incident that caused an injury to resident #010 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Review the resident's health record revealed an unidentified direct care staff member responded to the incident. Staff interviews revealed the unidentified staff as direct care staff member #146. Further review of the CIS revealed direct care staff member #146's name was not included in the report.

Interview with the ADOC confirmed that direct care staff member #146's name was not included in the report. [s. 104. (1) 2.]

2. A review of CIS on an identified date, identified resident #039 demonstrated responsive behaviours towards resident #040.

A review of the resident's health record did not reveal the direct care staff member who initially responded to the incident. Staff interviews revealed the unidentified staff as direct care staff member #132. Further review of the CIS revealed direct care staff member #132 and Registered staff member #158 names were not included in the report.

An interview with the DOC confirmed that direct care staff member #132 and Registered staff member #158's names were not included in the report. [s. 104. (1) 2.]

Issued on this 28th day of September, 2017

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

Original report signed by the inspector.