Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
May 8, 2018	2018_664602_0007	005511-18	Resident Quality Inspection

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Kentwood Park
2 Ontario Street PICTON ON K0K 2T0

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

WENDY BROWN (602), AMBER LAM (541), DARLENE MURPHY (103)

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): April 3-6 and 9-13, 2018.

The following intakes were completed concurrently with the Resident Quality Inspection:
Log #027433-17, CIS#0893-000012-17 - fall with transfer to hospital.
Log #005652-18, CO #002, s.19.(1) - resident abuse follow up - compliance date of February 5, 2018.

During the course of the inspection, the inspector(s) spoke with Residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Life Enrichment Coordinator (LEC), Activity Staff, Maintenance Staff, Corporate Office Staff, the Nutrition Manager, the Registered Dietician (RD), the Administrator, the Director of Care (DOC) and the Office Manager.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 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 #002	2017_664602_0032	602

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 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident at admission and monthly thereafter. Specifically, staff did not comply with the licensee's policy regarding "Weight Monitoring NC-1.9", effective Date: January 2014, which is part of the licensee's nutrition care and dietary service program.

During review of resident weights during this inspection, it was noted residents' #8, #19 and #33 had monthly weights missing.

Resident #8 was last weighed during a specified month, at which time the resident had a significant weight loss of 6.19%. The most recent nutritional assessment completed by the home's Registered Dietitian (RD) a specified number of months later, for resident #8 indicates the resident is at a high nutritional risk and refuses most of all meals.

Resident #19 had no monthly weights entered between a specified number of months at which time a weight loss of 14.2% was noted. Resident #19 is assessed as high nutritional risk. A progress note by the home's RD indicates resident #19 triggered a significant weight loss but indicated it was difficult to assess any trends as the previous weight was done a specified period of months previous. A review of the paper copy of the home's monthly weight sheets demonstrates that resident #19 had a weight completed during a specified month, however, it was not entered into mede-care.

Resident #33 is assessed as high nutritional risk and has not had a monthly weight entered since a specified month. Resident #33 had a significant weight gain between a specified period of months. A review of the paper copy of the home's monthly weight sheets demonstrates that resident #33 had a weight completed during a specified month however it was not entered into mede-care.

Inspectors noted while reviewing resident weights during the inspection that many residents were missing a weight for a specified month. A review of weights in mede-care demonstrates that nine residents had weights entered for a specified month. A review of the paper weight sheet indicates there were thirty - one residents who had weights

completed for the specified month.

The home’s policy NC-1.9 titled Weight Monitoring indicates that the PSW shall weigh each resident on their first bath day of the month and record the resident's weight on the form provided. The designated Registered Staff shall enter weights into each resident's clinical record through Mede-care. The Nutritional Care Manager shall run the Weight Report in mede-care and then:
- Review the report for completion and follow up with the Registered Staff if omissions are identified
- Review the report for accuracy and follow up with the Registered Staff if there are outstanding reweighs
- Report all changes in weight to the Registered Dietitian as required.
Policy NC-1.9 further states:
It is the responsibility of the Registered Staff to enter each resident's weight into their clinical record monthly;
It is the responsibility of the Nutritional Care Manager to review and prepare the weight report for the RD and to report changes in weight as per the requirements of this policy;
It is the responsibility of the DOC to ensure weights are taken and documented as per the requirements of this policy;
It is the responsibility of the Administrator to ensure compliance.

PSW #102 was asked about the home’s process for obtaining resident weights. PSW #102 stated residents are weighed at the beginning of each month and the weights are written on a sheet which is kept in the tub/shower room.
RN #101 was asked about the home’s process for inputting resident weights into the electronic charting system. RN #101 stated the home’s Nutritional Care Manager typically inputs the resident weights into the electronic chart, however, they will sometimes input the weight if a staff member informs them verbally of a recent, completed weight.

The home’s DOC was asked about the home’s process for obtaining resident weights and it was indicated the home tries to get all monthly weights done by the 5th of the month and the Nutrition Care Manager then inputs the weights.

The home did not follow their policy NC-1.9 titled Weight Monitoring in that monthly weights were completed but not entered in a specified month for twenty-two residents including resident #33. No weights were completed for seven residents during a specified month. Resident #19's weight was not entered into mede-care during a

specified month and monthly weights were not completed for resident #8 during a specified period of months. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Weight Monitoring NC-1.9 policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of maintenance services there are schedules and procedures in place for routine, preventive and remedial maintenance.

The following areas of disrepair were noted during the inspection include, but are not limited to, the following observations:

Room 5: portions of baseboard missing; in some areas exposing metal bead/rough edges; areas of gouging in paint.
Room 9: wall behind resident's bed has a large crack in the corner, paint/drywall has bubbles along crack
Room 11: wall under window beside resident bed has a large depression in the drywall.
Room 15: lower walls scratched, door frames and doors scratched, gouged, and have black markings, wall inside door has depression in drywall, seal at vanity and wall edge repair work not completed.
Room 16: dry wall repair at sink unfinished, wood exposed, drywall and paint along floor chipped walls and doors and frames, black markings, black marks on lower wall and doors and door frames various areas around bedroom and bedroom. Wall to the left of door upon entering room has disrepair that has been patched but not painted.

Staff member #106 was interviewed by Inspector #541 regarding the home’s process for preventative and remedial maintenance. Staff member #106 states that repairs are done as they are brought forward and every few years all the walls are painted. When asked how the home schedules regular room repairs to fix drywall and door frames, the staff member did not have a schedule or process in place to address the repairs.

The home’s Administrator also indicated to Inspector #541 the home has no schedule in place to identify preventative, routine and remedial maintenance. [s. 90. (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 specific to the implementation of schedules and procedures that ensure routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that misappropriation of resident monies was reported to the Director.

On a specified date, resident #033 indicated to inspector #602 that monies had gone missing on two occasions in the last six months. The missing monies were reported to the Administrator who investigated the issue and was unable to find the missing money, however, resident #033 advised that the situation had been resolved as the home reimbursed the full amount. In a different interview that same day inspector # 531 was advised by resident #035 that money had gone missing a few months prior; the issue was reported to the Administrator who reimbursed the monies.

On a specified date, resident #011 advised inspector #602 that monies had been taken from a purse. The resident reported the concern to the Administrator and indicated the situation was resolved as the monies were reimbursed.

The Administrator completed investigations and followed up with the resident(s) and resident POA(s) following each incident,however, the Director was not informed regarding the misappropriation of monies for residents #033, #035 and #011. [s. 24. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a physician or registered nurse in the extended class approved the restraining a resident #025.

Resident #025 was admitted to the home in 2016 and was assessed as high risk of falls. The resident was observed throughout the inspection to be wearing a restraint. PSW #102 and RPN #105 both indicated the resident required the restraint to prevent falls.

The resident plan of care related to restraints was reviewed and under, "Safety devices/Restraints" indicated, restraint on at all times while in wheelchair.

During the review of the resident health care record, there was no evidence found to support a physician or registered nurse in the extended class had ordered or approved the use of this physical restraint. The DOC was interviewed and indicated a belief that the resident was originally able to release themselves from the restraint and therefore a physician's order had not been required at that time. Resident #025 had been interviewed and observed by Inspector #103 and on two occasions was unable to demonstrate the ability to remove the restraint.

The licensee failed to ensure a physician or registered nurse in the extended class approved the restraining of resident #025 by a physical device prior to including it in the resident plan of care. [s. 31. (2) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of financial abuse - misappropriation of monies that the licensee suspects may constitute a criminal offence.

On a specified dates, resident #033 indicated to inspector #602 that monies had gone missing, on two occasions; Inspector #531 was advised by resident #035 that monies had gone missing from his/her room a few months ago and resident #011 advised inspector #602 that monies had been taken from a purse.

The missing monies were reported to the Administrator who investigated each of the three incidents; the missing monies were not located. The Administrator ensured that each of the residents were reimbursed and resident substitute decision makers were alerted as appropriate, however, the police force was not notified of the alleged or suspected incidents of financial abuse - misappropriation of monies, for resident's #033, #035 and #011. [s. 98.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a restraint, used for resident #028, was applied in accordance with the manufacturer's instructions.

On specified dates, resident #028 was observed to be seated in the wheelchair with a loosely applied restraint. The resident was observed frequently holding the restraint in their hands and during these observations the restraint was able to be held up to six inches away from the resident's body. This inspector observed the resident loosening the restraint, however, the resident was unable to unlatch the restraint when asked to.

PSW #102 and RPN #105 were both interviewed in regards to the application of this resident's restraint. Both indicated the retraint was in place as a fall prevention measure. Both staff members acknowledged that the restraint was loosely applied and stated the resident often plays with the restraint and will loosen it on their own. Both acknowledged the restraint was loosely applied but did not adjust the restraint at the time of the interviews.

The manufacturer's instructions for the restraint application was reviewed. The instructions warn that the restraint should be snug such that you can slide your flat open hand between the device and the patient. The instructions warn that loosely applied restraint may allow the patient to slide forward or down in the wheelchair and become suspended in the restraint which could result in chest compression and suffocation.

A discussion was held with the DOC who was unaware resident #028's restraint could be easily loosened by the resident.

The licensee failed to ensure a restraint used for resident #028 was applied in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

WN #7: 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 drugs were administered to residents #027 and #041 in accordance with the directions for use specified by the prescriber.

Resident #027 was ordered to receive a specified medication at specified times. In error, the resident was given an extra dose of a medication and an extra dose of another medication on a specified date and time.

Resident #041 was ordered to receive a medication. In error, the resident was given an extra dose of the medication on a specified date.

Neither of the residents experienced any adverse effects as a result of the medication incidents.

The licensee failed to ensure drugs ordered for residents #027 and #041 were given in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Medication incidents were reviewed from October 1, 2017 to January 30, 2018. MEDINC20852 occurred on a specified date. Resident #027 was administered in error an extra dose of a prescribed medication as well as an extra dose of another medication. The medication incident indicated the resident was monitored for ill effects. The resident health care record was reviewed and there was no documentation to reflect the assessment of the resident following the incident. Additionally, the incident report indicated the physician was not notified.

MEDINC21417 occurred on a specified date. Resident #041 was administered an extra dose of a medication. The medication incident indicated the resident was monitored for ill effects, however the resident health care record had no documentation to reflect the assessment of the resident following the incident.

The DOC was interviewed in regards to the above medication incidents and indicated the staff who discover an incident, report it and the DOC then completes the documentation using an on-line system. The DOC indicated any monitoring of the residents would be documented in the resident progress notes if the assessments had been completed. Additionally, the DOC stated the notifications to the resident/SDM as well as the physician would be documented on either the medication incident report or in the resident progress notes.

The licensee failed to ensure residents #027 and #041 were assessed following the medication incidents and also failed to ensure the physician was notified of the medication incident involving resident #027. [s. 135. (1)]

2. The licensee has failed to ensure all medication incidents are documented, reviewed and analyzed, corrective action is taken as necessary and a written record of everything is kept.

The DOC was interviewed in regards to MEDINC20852 and MEDINC21417. The DOC stated the practice was to meet with the staff member responsible for the incident to try and determine the cause and to discuss strategies to avoid a reoccurrence. The DOC indicated there were no written records to reflect the reviews or analysis. [s. 135. (2)]

3. The licensee has failed to ensure a quarterly review is undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents, any changes and improvements identified in

the review are implemented and a written record is kept of everything.

The DOC was interviewed in regards to the home’s process for reviewing medication incidents on a quarterly basis. The DOC stated the medication incidents are reviewed as a part of the Professional Advisory Committee (PAC) meetings that are held on a quarterly basis. The DOC stated the pharmacist reviews and summarizes the incidents that have occurred since the previous meeting and the incidents are discussed with the intent of reducing or preventing a reoccurrence. The DOC stated the home does not have a written record to reflect any changes or improvements made to prevent a reoccurrence. [s. 135. (3)]

Issued on this 20th day of June, 2018

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

Original report signed by the inspector.