Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2019	2019_526645_0012	011731-19, 015791-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 11, 12, 13, 19 and 20, 2019.

The following critical incidents with log# 015791-19 (M545-000039-19) related to fall prevention and management and log# 011731-19 (M545-000024-19) related to improper transfer, were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Operational Nurse manager (ONM), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Private Duty Sitters/Companions (PDSs) and Residents.

During the course of the inspection, the inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

A critical incident system (CIS), was received by the Ministry of Long-Term Care (MLTC) regarding an injury of resident #001 on an identified date.

Record review of the home's investigation note indicated that the resident was injured from an unknown cause. Further review of the progress note on the identified date indicated that the resident had a near miss incident during care provision, and PSW #102 was providing the care independently when the near miss incident occurred. The note also indicated that PSW #102 grabbed the resident to prevent the incident from occurring.

Review of the plan of care for resident #001 indicated that the resident required an identified type of staff assistance for care provision.

Interview with PSW #102 confirmed that they provided the care by themselves with no assistance from other staff members. The PSW further indicated that they were not aware that the resident required the identified assistance. They reiterated that it is the expectation of the home to review the resident's plan of care and provide the care as specified in the plan.

Inspector #645 reviewed the plan of care for residents #002 and #003, to increase the residents sample due to identified noncompliance for resident #001. Review of the plan of care for these residents indicated that they both required an identified type of care, within identified time intervals, to prevent altered skin conditions.

During separate interviews, PSWs #102, PSW #105 and Private Duty Sitter (PDS) #103, indicated that they provide the care randomly and do not follow the identified time intervals. The two PSWs also revealed that even though the plan of care directed them to do the care using the identified number of staff assistance within the identified time intervals, they mostly complete the care randomly and independently.

During the interview, the DOC reiterated that the plan of care outlines specific care needs of each resident and staff members at the home are expected to provide the care as specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that staff members who provide direct care to residents, were kept aware of the contents of the plan of care.

A). Review of the progress notes on the identified date indicated that resident #001 had a near miss incident during care provision. The note indicated that PSW #102 was providing care independently when the incident occurred. Review of the plan of care directed staff members to provide the care with another staff member's assistance.

During the interview, the PSW admitted to providing the care independently. PSW #102 indicated that they are the regular PSW for the resident and had been providing the care by themselves for a while. They stated that they were not aware that the resident needed a specific number of staff assistance for the care.

B). Record review of the plan of care for resident #002 reads as follows:

- the identified section of the resident's plan of care directed staff members to provide the identified care with the assistance from other staff members. The section of the plan of care also directed staff members to provide the identified care within specific time intervals.

Interview with PDS #103 indicated that they are the fulltime PDS for resident #002 during the day. The PDS indicated that they do most of the care by themselves, and they were not aware that the plan of care directed staff members to provide the care together with other staff members.

Record review of the plan of care for resident #004 reads as follows:

- the identified section of the resident plan of care directed staff members to provide the care with assistance from another staff member.

Interview with PDS #104 indicated that they are the part time caregiver for resident #004. The PDS indicated that they perform the identified care independently. During the interview, the PDS indicated that they were not aware that the plan of care directed staff members to provide the care with the help of other staff members.

Interview with the Operational Nurse Manager (ONM) confirmed that the plan of care for resident #002 and #004 directed staff members to provide the care with the help of

another staff member within specific time intervals. They reiterated that it is the expectation of the home that staff members review residents' plan of care and update themselves with the content prior to commencing care. [s. 6. (8)]

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 care set out in the plan of care is provided to the residents as specified in the plan, that and all staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, 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 where the Act or this Regulation required 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 plan, policy, protocol, procedure, strategy or system, was complied with.

A CIS was received by MLTC, regarding an injury of resident #002. The home's investigation record indicated that PDS #103 was providing care for resident #002 independently on the same day.

The home's policy, "Private Duty Sitter/Companion NU-0208-00", defined Private Duty Sitter and directed staff members and the home's management team to do the following:

A Private Duty Sitter/companion (PDS) is hired directly by the resident/family member. The registered staff will remain responsible for monitoring and evaluating overall resident care and service provided by the private duty Sitter/Companion.

The Nurse Manager will discuss the family's request for a Sitter/companion and based on the nursing assessment of the resident and advise the family on the suitable duties for a Sitter/Companion. The family member will be advised to complete the Family Acknowledgement for Sitters/Companions detailing the applicable Sitter/Companion duties.

The Sitter/Companion Acknowledgement document is a form that outlines specific roles and duties to be carried out by the Sitter/Companion for a specific resident. It is to be developed by nurses/nurse managers in consultation with the family of the resident. This document is to be signed by the family members and the Sitter/Companion prior to the start date.

The Sitter/Companion may provide basic personal assistance congruent with the Sitter/Companion Acknowledgement document and with the care plan in addition to companionship to the client/resident. The registered staff will provide instructions as required.

The resident/family/friends are expected to inform the Nurse Manager in writing, i.e. Family Acknowledgement for Sitters/Companions, of arranged services and consult with him/her throughout the term of service. The nurse will provide the family with documentation to familiarize the private duty Sitter/Companion to the home in order to deliver safe care by way of the Sitter/Companion Acknowledgement.

The home is to develop a process so as to allow all nursing staff to report any non-compliance/ sub standard care, service, assistance provided by a private Sitter/Companion to the registered staff and Nurse Manager.

Through discussions with the Family and based on nursing assessment, the Nurse Manager and Family will develop appropriate duties for the Sitter/Companion including but not limited to:

I. Days/hours to be worked by the Sitter
II. Develop specific duties (ADLs) and tasks to be carried out by the Sitter/Companion
III. Develop a process to notify the private Sitter when the care need changes from time-to-time
IV. Ensure that the family signs the Family Acknowledgement for Sitters/Companions form
V. Arrange for the Sitter to sign a Sitter/Companion Acknowledgment form
VI. Arrange for the Sitter to meet with the nurse manager to review duties and responsibilities
VII. Document the provision of Sitter/Companion service on care plan, specifying time of service, authorized tasks and all other pertinent data and
VIII. Inform the Sitter/Companion regarding: the home's standards and expectations regarding residents' rights, safety requirements, including but not limited to resident safety, fire safety and emergency procedures and any other routines that may impact on the Sitter/Companion's role.

During the interview, PDS #103 revealed that they don't have access to the resident's plan of care, and they were not sure about the identified care needs of the resident. They indicated that they are the regular Sitter for resident #002 for the past few years. PDS #103 revealed that they provide most of the resident's care independently when on duty. They indicated that the home did not provide them with the list of duties, tasks and specific care needs of the resident and no one notifies them when the resident care need changes. They also identified that they don't meet with the nurse or nurse managers regularly to discuss duties and responsibilities. They further indicated that they did not sign any contract with the home or the resident's family, and they were not sure about the Sitter/Companion Acknowledgment document. They never had any training at the home and not sure about the home's care standards and expectations regarding residents' rights, safety requirements, fire safety and emergency procedures.

Interviews with PDSs #104 and #110 also indicated that they did not sign the Sitter/Companion Acknowledgment document. They both indicated that the home did not provide them with any documentation that outlines the care needs of the residents, and they never met with the nurse manager to review duties and responsibilities. PDS #104 indicated that they became the Sitter for resident #004 recently, and they do not have access to the plan of care which identifies the care needs of the resident; they also did not receive any training about residents' rights, safety and emergency procedures.

Interview with ONM indicated that they were not sure about the home's "Private Duty Sitter" policy and the process associated with it. They indicated that they are aware that the PDSs did not sign the Sitter/Companion Acknowledgment document. The ONM admitted that they did not develop, outline and discuss the care needs of the residents with the PDSs or family members. The ONM confirmed that the home did not provide training on the home's care standards, and expectations as outlined in the policy. They reiterated that they will review the home's PDS policy, develop a process and arrange for the PDSs to sign the Sitter/Companion Acknowledgment document as required. [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 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 plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: 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 used safe transferring techniques when assisting residents.

A CIS report was received by the MLTC regarding an injury of resident #002 on an identified date.

Record review of the plan of care indicated that the resident required a specific number of staff members assistance for an identified type of care.

Record review of the home's investigation note indicated that resident #002 received the

identified care independently. On the same day, the resident was found with an injury to an identified part of their body. The investigation outcome did not determine if the resident was injured during the care.

During the interview, PDS #103 indicated that they did not recall the incident. However, during the home's investigation, the PDS admitted to providing the care independently.

Interview with the DOC confirmed that PDS #103 provided the identified care independently and confirmed that it was unsafe care provision.

2). A CIS report was received by MLTC regarding an injury of resident#001. The report indicated that the resident sustained the injury on an identified date.

Record review of the home's investigation note indicated that the resident was injured from an unknown cause. Further review of the progress note indicated that resident #001 had a near miss incident during care provision, and PSW #102 was providing the care independently when the incident occurred.

Review of the plan of care for resident #001 indicated that the resident required an identified number of staff assistance for the identified care.

During the interview, the PSW admitted that they provided the care with no other staff assistance and confirmed that the technique was unsafe.

3). During the course of the inspection, inspector also reviewed the plan of care for resident #004. The resident's plan of care directed staff members to provide the care with the assistance of another staff member.

Interview with PDS #104 indicated that they are the part time care giver for resident #004. The PDS indicated that they do perform the identified care independently and they do not seek assistance from the staff as the staff members at the home are mostly busy. [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 techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A CIS was received by MLTC regarding an injury of resident #001.

The home's policy titled " Skin and Wound Management #RC-0518-02 ", directed staff members to complete a specific type of assessment by using a specific type of

assessment tool, when a resident has altered skin conditions.

Record review of the progress note indicated that PSW #107 observed an altered skin condition and called RPN #106 to assess resident #001. The RPN observed the altered skin injury and called RN #108 for further assessment. Record review did not indicate if the RN completed the required assessments using the identified assessment tool.

The next day, the altered skin injury progressed and the same PSW notified RPN #106 to reassess the resident. The RPN called another RN, #109, for further assessment. Record review did not indicate if the RN completed the required assessment using the assessment tool. There was no documentation available describing the type, measurements, location, and odour of the altered skin injury.

Record review of the home's investigation note indicated that RNs #108 and #109 did not complete the required assessments and documentations. The records further indicated that a disciplinary counselling and training on assessments and documentations was provided for both staff members.

Interview with RPN #106 revealed that they called the RNs on both days so they would complete the necessary assessments and document findings. They indicated that the RNs have better knowledge, capacity and timing to complete a thorough assessment and complete the required documentations.

Interviews with RN #108 and #109 confirmed that they did not complete the required assessments using the tool. Both RNs reiterated that it is the expectation of the home to complete the assessments and document findings when a resident has altered skin conditions.

Interview with the DOC indicated that it is the home's expectation that registered staff complete the assessments using the home's assessment tool and confirmed that the registered staff did not use the assessment tool and document findings as expected. [s. 50. (2) (b) (i)]

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 exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 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 were documented.

A CIS report was received by MLTC, regarding an injury of resident #002. The report indicated that the resident sustained injuries to an identified part of the body.

Record review of the current plan of care indicated that resident #002 required an identified type of care within specific time intervals. Further review of the clinical records indicated that there was no documentation available regarding the care provision within the time intervals. Record review of the plan of care for resident #003 also indicated that they needed the identified type of care within the identified time intervals. During the record review, Inspector #645 was unable to locate any documentation regarding the care provision for resident #003.

Interview with PSW #106 confirmed that they randomly provide the care and they do not document the provision of care. Interview with PDS #103 also confirmed that they do not document the care provision.

Interview with the ONM confirmed that there was no documentation available and staff members are expected to document the care provision at all times. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's pain management program to identify and manage pain in residents was implemented in the home.

Review of the home's policy tiltled "Pain Assessment and Management, RC-0518-01" under the home's pain management program directed staff members to complete pain assessment using "Edmonton" assessment tool when a resident is cognitively intact and "Abbey" assessment tool when the resident is cognitively impaired. The policy indicated the following:

-complete pain assessment when the resident is a new admission, when there is altered skin condition, significant change to the resident's health condition and when pain is not relived following the initial pain treatment.

A CIS was received by MLTC regarding an injury of resident #001 on the identified date.

Record review of the progress note indicated that the resident had an identified medical condition that caused severe intellectual/cognitive impairments. Record review of the note on the identified date, indicated that the resident had an injury to an identified part of their body and also sustained altered skin conditions that was painful upon touch. Record review of the progress note on the identified date indicated that the resident was assessed by RPN #106 and RN #108. The note also indicated that the resident was assessed the following day by RN #109.

Record review did not indicate if the registered staff completed pain assessment on both days. There was no documentation available describing the type, severity, quality, location, onset, duration, and precipitating factors of the pain.

Record review of the home's investigation note indicated that RN #108 and #109 did not complete the required assessments and documentations. The records further indicated that a disciplinary counselling on assessment and documentation was provided for both staff members.

Interviews with RN #108 and #109 confirmed that they did not complete pain assessment after they were notified by RPN #106. Both RNs reiterated that it is the expectation of the home to complete a pain assessment specially when a resident has pain. RN #108 indicated that resident #001 is cognitively impaired and the home uses "ABBEY" assessment tool that scores/rates the resident's facial expressions and physiological changes to assess pain level.

Interview with the DOC indicated that under the home's pain management program, registered staff are expected to complete pain assessments using the home's specified pain assessment tools when a resident exhibits pain and confirmed that the registered staff did not implement the home's pain management program. [s. 48. (1) 4.]

Issued on this 29th day of October, 2019

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

Original report signed by the inspector.