Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 6, 2016	2016_247508_0014	027884-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

LINHAVEN
403 Ontario Street St. Catharines ON L2N 1L5

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

ROSEANNE WESTERN (508), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 22, 23, 26, 27, 28, 29, 30, October 4, 5, 6, 2016.

During this RQI the Inspectors toured the home, observed resident care, dining service, reviewed clinical records, incident reports, internal investigative notes, complaint log, staff training records and relevant policies and procedures.

The following inspections were conducted simultaneously with this inspection: Critical Incidents (CI) - log #034683-15 and #001087-16, related to falls. Complaint inspections - log #032334-15, related to a fall with injury, #003320-16, related to alleged staff to resident abuse, #026658-16, related to resident care concerns. The following inquiries were conducted: #000760-14, #007105-14, #002270-14, #002879-14, #010115-14, related to resident responsive behaviours, #018258-16, related to alleged financial abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Resident Care (DRC), Associate Director of Resident Care (ADRC), Food Service Manager (FSM), Clinical Documentation and Informatics Leads (CDIL), dietary staff, Personal Support Workers (PSW), registered staff, Residents' Council President, Family Council President, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

It was observed on an identified date during this inspection that resident #008 was sitting in their wheelchair with a positioning device secured to the chair. The resident's device had been applied at 0655 hours that morning.

A review of the resident's plan of care indicated that this device was a Personal Assistance Service Device (PASD) used for positioning purposes. The resident's plan of care directed staff to check the PASD to ensure safety of the resident and to release the PASD every two hours.

An interview with staff #106 indicated that she was assigned to resident #008 but had not yet removed the PASD since it was applied at 0655 hours. Three other staff working on this unit were interviewed and confirmed that they had not released the resident's PASD.

It was confirmed by PSW staff and the Director of Resident Care (DRC #100) that the care was not provided to resident #008 as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed.

On an identified date in 2016, resident #100 had a fall with injury that resulted in a significant change. The post fall assessment that was completed identified specific interventions that would be put in place. In an interview with Clinical Documentation Informatics Lead (CDIL #103) it was confirmed that the falls care plan was not reviewed and revised to include these interventions. It was confirmed by the DRC (#100) that when resident #100 had one fall from their bed on an identified date, and two falls from their bed two days later, that these specific interventions were not documented in the falls care plan interventions.

PLEASE NOTE: This area of non-compliance was identified during a Critical Incident report inspection, log # 001087-16, conducted concurrently during this RQI. [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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 failed to 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.

During an observation and review of resident #001's plan of care it was identified they had a restraint. The plan of care identified that the resident was to be released from their restraint, repositioned and the restraint reapplied every two hours. The point of care documentation was reviewed over a seven day period in September, 2016. Resident #001's intervention of having their restraint released, repositioned and restraint reapplied every two hours while their restraint was applied was not documented as being done per the plan of care on six identified dates in September, 2016. This was confirmed in an interview with the DRC (#100), on October 30, 2016.

During an observation and review of resident #102's plan of care, it was identified they had a restraint. The plan of care identified that the resident was to be released from their restraint, repositioned and the restraint reapplied every two hours. The point of care documentation was reviewed over a seven day period in September, 2016. Resident

#102's intervention of having their restraint released, repositioned and restraint reapplied every two hours while their restraint was applied was not documented as being done per the plan of care on six identified dates in September, 2016. This was confirmed in an interview with the DRC (#100), on October 30, 2016. [s. 30. (2)]

2. Resident #202 was admitted to the home on an identified date in 2016 . A review of the resident's clinical record indicated that the resident had not been offered or received a tetanus/diphtheria immunization upon admission.

During an interview with the Director of Resident Care (#100), the DRC indicated that the resident had been offered the immunization upon admission; however, the resident refused at that time. The Registered Nurse (RN) had not documented that she had offered the immunization or that the resident refused the immunization.

It was confirmed by the DRC (#100) on October 4, 2016, that the resident was offered and refused the immunization upon admission; however, this had not been documented. [s. 30. (2)]

3. Resident #008 had a device defined as a Personal Assistance Service Device (PASD) to be applied to the resident's wheelchair while up in the chair to assist with positioning. Staff were to document all actions taken with the care of the resident while using the PASD including when it was applied, released, reapplied, checked and removed.

A review of the Point of Care (POC) documentation over a two week period in 2016, indicated that staff had not documented all actions taken. Over this 14 day period, it had not been documented on two dates that the PASD had ever been applied when staff had documented on the same dates that they had checked it.

It was not documented when the device was removed at the time of the transfer for 11 of the 14 days and it was not documented that the PASD was released, the resident repositioned and the device reapplied every two hours over this 14 day period.

It was confirmed by the DRC (#100) during an interview on October 4, 2016, that staff had not documented all actions taken with respect to the PASD for resident #008. [s. 30. (2)]

Additional Required Actions:

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

WN #3: 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 failed to ensure that when a resident was restrained by a physical device that the physical device was applied in accordance with any manufacturer's instructions.

During this inspection, resident #102 was observed in the dining room on their unit. Resident #102 was facing the wall and had slid down in their wheelchair. The resident's restraint was observed to be fastened around the resident's chest area. Registered nursing staff #112 and #113 observed resident #102 and shared that the resident had been sliding out of their wheelchair approximately every ten minutes and required frequent repositioning. In a progress note completed by the Occupational Therapist (OT), resident #102's wheelchair and restraint were assessed because the resident was sliding out of their chair and required constant repositioning.

In an interview with the DRC (#100), on September 30, 2016, it was confirmed that during the time period required for the OT recommendations to be implemented, the home had not put in place interventions to ensure the resident's restraint would remain applied as per the manufacturer's instructions.

A review of the restraint guide identified that the restraint should be positioned in a specific way with the person seated. In an interview with registered nursing staff #112 and #113 it was confirmed that resident #102's restraint was not applied as per the manufacturer's instructions. [s. 110. (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 when a resident is restrained by a physical device that the physical device is applied in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal.

During a lunch observation on September 22, 2016, in the dining room located on Lincoln unit it was observed that residents were not offered tomatoes on their hamburger or broccoli salad as per the planned menu.

In an interview with the dietary aide (DA), it was confirmed that the items were unavailable for them to serve. In an interview with the Food Service Manager (FSM) it was confirmed that residents were offered a garden salad for both meal choices as the product to make the broccoli salad was not available. [s. 71. (4)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods; O. Reg. 79/10, s. 72 (2).
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system at a minimum, provided production sheets for all menus and documentation on the production sheets of any menu substitutions.

During interviews with residents on September 23 and 26, 2016, and upon review of the 2016 Residents' Council and Family Council meeting minutes it was noted food production concerns were being brought forward. It was identified that residents were not always being offered two choices as the home was running out of some of the food choices before all residents were served.

During an observation in the kitchen on October 5, 2016, it was observed the cooks had no production sheets to follow when preparing the dinner service. In an interview with the Food Service Manger on October 5, 2016, it was confirmed the home did not have production sheets in place and that menu substitutions were not being recorded on production sheets. It was confirmed that menu substitutions documented on the production sheets for the past year were not available. [s. 72. (2)]

2. The licensee failed to ensure that the staff of the home complied with the cleaning schedule for all equipment and servery areas.

During a lunch observation on September 22, 2016, in the dining room on Lincoln unit the servery cupboards, counters and floors were observed to be unclean and covered with dust. Two food carts observed to be used to serve food items to the residents were unclean with dried food debris. A review of the cleaning schedule identified the servery and carts were to be cleaned after each meal service.

In an interview with the Food Service Manager on October 5, 2016, it was identified construction had been completed in the Lincoln unit servery and that the servery had not been deep cleaned prior to the first meal service. It was confirmed that the servery and carts were not cleaned as per the homes cleaning routines. [s. 72. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included every date on which a response was provided to the complainant and a description of the response.

A review of the home's investigation records identified a written compliant was made to staff members of the home on an identified date in 2016, which concerned the care of residents. In written communication from the complainant to the Administrator and DRC (#100), the complainant requested they be informed of the outcome of the investigation. In an interview with DRC (#100) , on November 5, 2016, it was confirmed that the home did not have any documented records of the date or description of the responses provided to the complainant after the home's investigation had been completed.

It was confirmed that the home had no further documented responses to the complainant after the complaints last written concerns.

PLEASE NOTE: This area of non-compliance was identified during a Complaint report inspection, log #003320-16, conducted concurrently during this RQI. [s. 101. (2) (e)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection and prevention control program.

It was observed during a tour of the facility on September 22, 2016, that in the Lincoln unit tub room there were resident's personal items such as razors that were not labelled to identify who they belonged to.

Resident personal hygiene items which contained uncapped razors and a comb were also observed in a box which had some hair and the bottom of the box was soiled with a coating of a brown coloured substance. A box containing individual resident's nail clippers had nail clippings scattered over the bottom of the box where the nail clippers were stored.

On September 27, 2016, it was observed in a bathroom shared by two residents that there was a kidney basin (K-basin) and a denture brush on the counter not labelled.

On the same unit, in a resident's bathroom shared by two residents there was a urinal, a k-basin containing a toothbrush that were not labelled, and a denture cup that had been labelled; however, the label had been partially removed and the resident's name was no longer visible.

It was confirmed by PSW staff that resident's personal items should be labelled in rooms where more than one resident share a bathroom. It was also confirmed by the DRC (#101) that the resident's personal items should be labelled and stored in a clean manner in resident tub and shower rooms. [s. 229. (4)]

Issued on this 10th day of November, 2016

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

Original report signed by the inspector.