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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2019	2018_661683_0022	027181-17, 029699-17, 005440-18, 005520-18, 019838-18, 026281-18, 026460-18, 026775-18, 030805-18, 032695-18	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way 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

LISA BOS (683), AILEEN GRABA (682), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 17, 18, 19, 20 and 21, 2018, and January 2, 3, 4, 7, 9, 10, 11, 14, 15, 16, 17, 18, 22 and 23, 2019.

This inspection was completed concurrently with follow up inspection

#2018_661683_0020 and critical incident inspection #2018_661683_0021.

The following intakes were completed during this complaint inspection:
027181-17, IL-54299-HA - related to the prevention of abuse and neglect, continence care and bowel management, personal support services, falls prevention and management
029699-17, IL-not available - related to falls prevention and management, staffing
005440-18, IL-56073-HA - related to plan of care, continence care and bowel management, responsive behaviours, personal support services
005520-18, IL-56102-HA/IL-56184-HA - related to medication administration, prevention of abuse and neglect
019838-18, IL-58584-HA - related to the prevention of abuse and neglect, continence care and bowel management, personal support services
026281-18, IL-60389-HA - related to the prevention of abuse and neglect, nutrition and hydration, plan of care
026460-18, IL-60468-HA - related to housekeeping, nutrition and hydration, continence care and bowel management, personal support services
026775-18, IL-60602-HA/IL-60986-HA - related to the prevention of abuse and neglect, plan of care, falls prevention and management
030805-18, IL-61845-HA - related to staffing
032695-18, IL-not available - related to restraints, prevention of abuse and neglect

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6(10)(c), identified in a concurrent inspection #2018_661683_0021 (log #021651-18, CIS #M551-000030-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Associate Directors of Resident Care (ADRC), the Manager of Long Term Care Behavioural Support and Convalescent Care, the Dietitian, the Resident and Family Support Worker, registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed the complaints log, reviewed meeting minutes, reviewed program evaluation records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (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.

A) A complaint log #026775-18 was submitted to the Director on an identified date, and identified concerns about various care areas. A clinical record review indicated that resident #010 was assessed as an identified risk of falls on an identified date. The plan of care that comprised the care plan, last reviewed on an identified date, included specific fall prevention interventions.

i) A clinical record review included a progress note that indicated that on an identified date, a specific intervention was not in place. During an interview on an identified date, Registered Nurse (RN) #114 confirmed that the identified intervention was not in place on an identified date, for an identified length of time.

ii) A clinical record review included a progress note that indicated that on an identified date, specific equipment for resident #010 was not in working condition. During an interview on an identified date, Registered Practical Nurse (RPN) #133 stated that the identified equipment was not in working condition for an undisclosed period of time and confirmed that identified interventions were not in place for an undisclosed period of time.

RN #114 and RPN #113 stated that the care set out in the plan for resident #010 for falls prevention was not provided to the resident as specified in the plan.

B) A complaint log #026775-18 was submitted to the Director on an identified date, and

identified concerns about various care areas. A clinical record review indicated that resident #010 had a specific assessment completed on an identified date, for an identified reason. The plan of care that comprised the care plan, last reviewed on an identified date, indicated that resident #010 was an identified risk for a specific care area and included a specific intervention to be completed by the personal support worker (PSW) staff at an identified time interval. During an interview on an identified date, PSW #110 stated that resident #010 was dependent on assistance with an identified aspect of care. PSW #110 also confirmed that they were responsible for ensuring that resident #010's care needs regarding a specific care area were met by the identified intervention on an identified date. Observations by Inspector #682 done on an identified date, confirmed that the identified intervention was not completed by PSW #110 or any other staff to resident #010 between identified hours, on an identified date. During an interview on an identified date, PSW #110 stated that they did not complete the identified intervention to resident #010 between the identified hours and the home did not ensure that the care set out in the plan for resident #010 in relation to the identified care area was provided as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) A complaint log #026775-18 was submitted to the Director on an identified date, and identified concerns about various care areas. A review of the plan of care that comprised the care plan, last reviewed on an identified date, included specific interventions for an identified care area. Further clinical record review included a progress note from an identified date, where specific requests were made in relation to resident #010's care. During an interview on an identified date, RPN #105 stated that the care plan was accessed by all staff to determine resident care needs and that any registered staff could update the care plan with changes. RPN #105 also stated that the plan of care that comprised the care plan was not updated and did not include the specific request for resident #010's care. RPN #105 stated that they failed to revise the plan of care when resident #010's needs changed. (682)

B) During review of resident #003's clinical records for complaint inspection log #027181 -17, it was identified that resident #003 had a history of an identified medical condition. The staff at the home were verbally informed that the resident had a history of the identified medical condition and specific ways in which the condition affected the

resident.

These conversations were documented and confirmed during review of the resident's clinical record. In an identified time period, the resident had an identified diagnosis an identified number of times and on an identified date, the resident was diagnosed with the identified condition and it resulted in a change in their health status.

A review of the resident's current electronic plan of care indicated that the plan had not been updated to identify that the resident had a history of the identified medical condition. Further review of the record, specifically under the tab titled Medical Diagnosis, also had not been revised with this information.

During interview with registered staff #107 on an identified date, the staff reviewed the resident's clinical record and indicated that the resident's plan of care should have been updated with the history of the identified medical condition.

It was confirmed during record reviews and during interview with registered staff #107 that the resident's plan of care was not reviewed and revised at least every six months and at any other time when the resident's care needs changed. (508)

C) A review of complaint log #026460-18 identified concerns related to specific care areas.

A review of the written plan of care for resident #005, last reviewed on an identified date, indicated the resident's preference for a specific care area. A review of the Point of Care (POC) documentation from an identified time period, indicated that the resident received care on six identified dates that was not consistent with their documented preference. There was no documentation during the identified time period of the resident receiving the identified care as per their preference, aside from one instance, on an identified date.

In interviews with PSW #104 and RPN #103 on an identified date, they indicated reasons why specific care was not provided in the identified home area for an identified time period. Observations made by Inspector #683 on an identified date indicated a piece of equipment that was labelled as not in service.

In an interview with Associate Director of Resident Care (ADRC) #106 on an identified date, they indicated that they asked staff to try an identified intervention for an identified period of time, but indicated that the request was no longer in effect. On an identified

date, ADRC #106 indicated that after discussion with staff it was confirmed that resident #005's preference for the identified care area was consistent with what they were being provided. They acknowledged that the resident's written plan of care identified a specific preference for their care and that their plan of care was not revised when the resident's care needs changed.

The home did not ensure that resident #005's written plan of care was revised to identify their preference for an identified care area. [s. 6. (10) (b)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and any other time when the care set out in the plan was not effective.

A) A review of complaint log #027181-17 identified specific concerns related to resident #003's care.

A review of the electronic record for resident #003 identified that on an identified date, the resident sustained a fall. Under "the current interventions and/or action plan that have been considered" the post fall assessment identified a specific intervention. On an identified date, the resident sustained another fall and a specific intervention was identified in the post fall assessment as a current intervention and/or action plan that was considered. On an identified date, the resident sustained another fall and the post fall assessment identified a specific reason for the resident's fall. The post fall assessment identified that a specific intervention would be implemented.

A review of the written plan of care for resident #003 identified that they were at an identified risk of falls and they had specific interventions in place to prevent falls. A review of the written plan of care on an identified date, indicated that a specific falls prevention intervention was added to the resident's written plan of care on an identified date.

In an interview with ADRC #115 on an identified date, they acknowledged that resident #003's care plan was not revised when the registered staff indicated in the post fall assessments that the specific falls prevention intervention was a possible intervention until an identified date. ADRC #115 identified that the specific falls prevention intervention was readily available to the staff and indicated that staff often used the specific intervention. They identified that staff may have provided the resident with the identified intervention between the identified time period, but it was not documented.

The home did not ensure that resident #003's plan of care was revised after their falls on the identified dates, when the falls prevention interventions in place at the time were not effective.

B) PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2018_661683_0021 and was issued in this report.

A review of Critical Incident (CI) log #021651-18 / M551-000030-18 identified that on an identified date, resident #001 sustained a fall that resulted in an identified injury.

A review of the clinical record for resident #001 identified that they were at an identified risk of falls and had a history of falls. A review of their written plan of care identified specific interventions to prevent falls.

A review of the clinical record identified that the resident sustained an identified number of falls between an identified time period, and specific interventions were trialed and considered to try and prevent falls for the resident.

In an interview with ADRC #106 on an identified date, they reviewed resident #001's written plan of care and acknowledged that their care plan was revised on an identified date, after an identified fall, to identify a specific falls prevention intervention. They acknowledged that the resident's plan of care was not revised after their falls on an identified number of dates, when the falls prevention interventions in place at the time were not effective. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan and 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 resident's care needs change or care set out in the plan is no longer necessary and when the care set out in the plan has not been effective, 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 failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

A) In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, registered staff did not comply with the licensee's policy titled "Nutrition and Hydration," Index No: PCS05-010, last revised May 20, 2016.

A complaint log #026775-18 was submitted to the Director on an identified date, and identified concerns about various care areas. Point of Care (POC) records were reviewed for an identified care area on identified dates. The plan of care that comprised the care plan, last reviewed on an identified date, indicated that resident #010 was at risk for an identified condition. During an interview on an identified date, the registered dietitian stated that based on the documentation for the identified dates, a specific assessment should have been completed by registered staff when specific criteria were met.

During an interview on an identified date, RPN #105 stated that resident #010 was at risk for an identified condition and if the resident met specific criteria, the registered staff were to complete a specific assessment. RPN #105 stated that the identified assessment for the identified dates were not done and that the home did not comply with the identified policy.

B) In accordance with O. Reg. 79/10, s. 52 (1), the licensee was required to ensure the pain management program must, at a minimum, provide for the following: 4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

Specifically, registered staff did not comply with the licensee's policy titled "Pain Assessment and Management Program policy," Index No: MP00-004, last reviewed on an identified date, which states:

"Upon admission and re-admission registered staff will assess a resident for pain and complete the pain assessment in Point Click Care (PCC)."

A complaint log #026775-18 was submitted to the Director on an identified date, and identified concerns about various care areas. A review of the plan of care that comprised the care plan, last reviewed on an identified date, included a focus for an identified care area related to specific conditions. A review of progress notes indicated that resident #010 was re-admitted to the home on an identified date. A review of the progress notes for an identified date indicated that resident #010 was experiencing pain.

During an interview on an identified date, ADRC #115 stated that resident #010 did not have a pain assessment done using a clinically appropriate tool when they were re-admitted to the home on an identified date or on an identified date when they exhibited pain. ARDC #115 stated that the home did not assess the resident as stated in the policy. The home failed to ensure monitoring of resident #010's responses or

effectiveness of the pain management strategies. [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 where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice, unless contraindicated by a medical condition.

A review of complaint log #026460-18 identified concerns related to specific care areas.

A review of the written plan of care for resident #007, last reviewed on an identified date, indicated the resident's preference related to bathing. A review of the Point of Care (POC) documentation from an identified time period indicated that the resident was bathed on eight identified dates by a specific method that was not consistent with their documented preference. There was no documentation during the identified time period of the resident being bathed by their documented preference or of the resident refusing to be bathed by the method of their documented preference.

In interviews with PSW #104 and RPN #103 on an identified date, they indicated reasons why specific care was not provided in the identified home area for an identified time period. Observations made by Inspector #683 on an identified date indicated a piece of equipment that was labelled as not in service.

In an interview with ADRC #106 on an identified date, they indicated that they asked staff to try an identified intervention for an identified period of time, but indicated that the request was no longer in effect. In an interview with ADRC #106 on an identified date, they acknowledged that resident #005 was not bathed by the method of their choice on the identified dates. [s. 33. (1)]

Issued on this 21st day of February, 2019

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

Original report signed by the inspector.