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

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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
Apr 4, 2019	2019_587129_0004	003519-17, 005145-17, 006088-17, 025464-17, 004017-18, 020131-18, 000449-19	Complaint

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Macassa Lodge
701 Upper Sherman Avenue HAMILTON ON L8V 3M7

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

PHYLLIS HILTZ-BONTJE (129), KELLY HAYES (583)

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): February 7, 8, 11, 12, 13, 15, 19, 20, 21, 22, 25, 26, 27, 28, March 1, 4, 6, 7, 2019.

The following intakes were completed during this complaint inspection:
003519-17 related to resident abuse/neglect.
005145-17 related to providing assistance to resident, falls prevention, bed rails,

nurse call system and mobility aids.
006088-17 related to pain management, falls prevention and continence care.
025464-17 related to resident abuse.
020131-18 related to reporting complaints, recreation programs, response to nurse call system and medication management.
000449-19 -related to skin/wound, weight changes and menu planning.
019660-17-related to abuse.

Please note:
A Voluntary Plan of Correction (VPC) related to LTCHA 2007, c. 8, s. 19 (1) identified during Critical Incident inspection #2019_756583_0005 related to Log # 00834-17 and CIS # M552-000024-17, that was conducted concurrently with this Complaint Inspection has been issued in this report.

Please note:
A Voluntary Plan of Correction (VPC) related to related to LTCHA2007, c. 8, s. 6 (10) (b) identified during Follow-up Inspection #2019_756583_0006 related to Log #005598-18, that was conducted concurrently with this Complaint Inspection has been issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Cooks, Food Service Supervisor, Food Service Workers, Nursing Managers, Registered Dietitian, Social Workers, Supervisor of Administrative Services, Administrative Assistant, Director of Nursing and the Senior Administrator.

During the course of this inspection, the inspector(s) reviewed resident clinical records (both computerized records and hard copy records), observed residents and care provided to residents, observed resident's environments, observed meal services, reviewed staffing schedules, reviewed records maintained by the home (investigative notes, training records, annual program evaluations), meal planning production sheets and recipes as well as reviewed relevant licensee's policy and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Medication
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **7 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. (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 resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan of care was no longer necessary.

a) Resident #004 was not reassessed and their plan of care was not reviewed and revised when the resident fell on an identified date in 2017, which resulted in multiple changes related to the resident's care needs.

Clinical documentation confirmed that resident #004 fell on the identified date and at the time sustained two identified injury and experienced pain.

Over the course of the following seven days, staff documented in the clinical record that they observed an ongoing decline in seven identified care areas.

A review of resident #004's written plan of care, specifically, the care plan that was used by the home to identify care interventions to the staff responsible for providing direct care to the resident, indicated there had been no new care interventions established or documented related to the above noted changes.

At the time of this inspection it was acknowledged during interviews with the Senior Administrator, Director of Nursing (DON) and staff #104 that the care plan did not identify the changes in care needs demonstrated by the resident and there were no direction documented in the written plan of care for staff in the management of the identified care needs over the above noted period of time. (129)

b) While completing Follow-up Inspection #2019_756583_0006, Log # 005598-18, related to weekly skin and wound assessments it was identified that resident #013's plan of care had not been reviewed or revised when the care set out in their plan of care was no longer necessary.

Resident #013's plan of care identified they were at risk of skin breakdown and previously had a treatment applied to an identified area of altered skin integrity. The resident's treatment ordered on an identified date in 2018, and documented in the Treatment Administration Record (TAR), directed staff to apply a specific product over the identified area on two specified days of the week.

On an identified date in 2019, an initial skin and wound assessment was completed and resident #013 was assessed to have an identified area of altered skin integrity on the same area identified above. A new treatment was ordered on an identified date, which directed staff to cleanse the area with an identified solution, apply an identified substance and cover the area with a specific product every two days.

In an interview with RPN #108 on an identified date in 2019, it was confirmed resident #013's area of altered skin integrity had reopened and the treatment for their altered skin integrity had changed. A review of the TAR showed that there were two different treatment orders for the identified area on the identified date in 2018 and an identified date in 2019, and both were being signed by registered nursing staff. In an interview with Nurse Manager #119 on an identified date, it was confirmed that when resident #013's skin was reassessed on the identified date in 2019 and their skin care needs changed the previous TAR order from the identified date in 2018, was not removed when it was no longer necessary. (583) [s. 6. (10) (b)

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 plan of care had not been effective.

a) Resident #002's plan of care was not reviewed and revised when care interventions related to the management of pain had not been effective in achieving the established goal of care that the resident would have no pain.

Clinical notes recorded in resident #002's computerized record indicated the resident experienced pain at an identified location on an identified date in January 2017 and four identified dates in February 2017.

Medication Administration Records (MAR) indicated the resident received a regular dose of an identified analgesic medication twice a day at 0800 and 1600 hours and this medication had been administered to the resident since 2015.
Medication Administration Records for January 2017 and February 2017, identified that the resident's physician had ordered that staff could administer a second identified analgesic medication every four hours as necessary. The January 2017 MAR indicated that staff administered this medication six times. The February 2017 MAR indicated that staff administered this medication six times.

Minimum Data Set (MDS) coding completed on an identified date in January 2017,

confirmed registered staff coded that during the observation period the resident had no pain. The following MDS coding completed on an identified date in March 2017 also confirmed that during the observation period registered staff had coded that the resident had no pain.

During an interview, Nurse Manager #112 verified the above noted dates when resident #002 experienced pain, confirmed that there was no evidence in the clinical record that staff had reviewed the issue related to pain management between the identified date in January and March 2017, and there had been no revision to resident #002's plan of care when care interventions had not been effective and resident #002 continued to experience pain during the above noted period of time. (129)

b) Resident #002's plan of care was not reviewed or revised when care interventions related to the prevention of falling had not been effective in achieving the established goals of care that the number of falls the resident had would decrease and the resident would have no falls.

Clinical notes recorded in resident #002's computerized record indicated the resident fell on two identified dates in 2017 and most recently fell on an identified date in 2018.

During an interview with Nurse Manager #112 and following a review of resident #002's plan of care they verified that there was no evidence in the clinical record that staff had reviewed or revised the plan of care following the falls the resident experienced on the two identified dates in 2017 or the most recent fall the resident experienced on the identified date in 2018. Nurse Manager #112 acknowledged that the goal of care was to reduce the number of falls the resident experienced and the resident would have no falls, that there were no additional interventions added to the plan of care to prevent the resident from falling after the above noted falls and interventions in place at the time of the above noted falls had not been effective and the resident continued to fall. (129)

c) Resident #012's plan of care was not reviewed or revised when care interventions related to the prevention of falling had not been effective in achieving the established goal of care, which was identified as "decreasing the numbers of falls and the resident would have no falls".

A review of progress notes made by registered staff indicated the resident fell nine times over a four month period of time in 2018/2019.

During an interview with PSW #105 they confirmed that the resident had a care device in place on their bed at the time of the above noted falls, and explained that sometimes the care device did not work and/or was not effective.

During an interview with resident #012 they confirmed that they did have a care device for their chair and they acknowledged that they disengage the device.

During an interview with Nurse Manager #112 and following a review of resident #012's plan of care they verified that there was no evidence in the clinical record that staff had reviewed or revised the plan of care or added addition care interventions to decrease the number of falls the resident experienced following any of the above noted falls and the resident continued to fall. (129) [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 and ensure that the resident is assessed and the plan of care reviewed and revised when the resident's care needs change, care set out in the plan is no longer necessary or care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were safe.

a) On an identified date during this inspection, breakfast service was observed in an

identified home area. Scrambled eggs were on the menu. The "Therapeutic Summary" used to provide direction to the Food Service Worker (FSW) severing the food at each meal service directed staff to provided scrambled eggs for residents on specified diets and a different textured scambled egg for those on another diet texture. All residents were observed to be served the same scrambled eggs.

The pan of scrambled eggs was observed to be one solid custard consistency. The eggs mixture around the edges of the pan was observed to be a drier consistency and once the FSW started serving eggs to the residents the solid egg pieces broke into smaller, separated pieces of egg. Inspector #583 confirmed with Food Service Worker (FSW) #125 serving breakfast, that there used to be two different textured scrambled egg entrees, but the home had changed to using one consistency for all resident some time ago and the "Therapeutic Summary" had not been updated to reflect this.

Inspector #583 went to the kitchen and observed the "Macassa Lodge Foodservice Production Sheets – February 25 – March 3, 2019", used to direct the cook how much to prepare and what texture modification was required for each menu item. The production sheet directed the cook to prepare two types of scrambled eggs and a standardized recipe was located in the binder for each texture.
In an interview with cook #114, it was confirmed the home had changed the recipe and one scrambled egg product was being prepared for all resident textures and a copy of a hand written recipe that was posted in the kitchen was provided. It was identified that the eggs were sent to each servery the day before and cooked using a re-therm process and that previously, one texture of eggs was being prepared the day of service and required the FSW staff to come to the kitchen to pick up the eggs prior to starting breakfast service.

In an interview with Food Service Supervisor (FSS) #116 during this inspection, it was confirmed the recipe binder, production sheets and therapeutic sheets had not been updated to reflect the recipe the home was currently using and did not provide clear direction. It was identified that this change was made approximately six months ago.

On an identified date, a referral was sent to the Registered Dietitian (RD) by the registered nursing staff as staff identified a resident safety issue related to the eggs. An identified resident was assessed the following day during breakfast service and it was identified the eggs served to the resident were not a smooth, cohesive texture.

In an interview with the Director of Food Services on an identified date it was confirmed

that the scrambled eggs were a more solid texture on the side of the pan and that the egg did break into separated pieces once a FSW started serving portions to residents. It was shared in order to ensure residents on an identified diet received a smooth, cohesive, custard like texture, staff would need to scoop portions from the centre of the pan. It was shared all residents on the identified diet would need to have their eggs portioned first at the beginning of the service. At the time of the interview it was confirmed that there were no directions on the "Therapeutic Summary" or in the servery areas to direct the FSW staff on how to serve eggs to residents on the identified diet. Staff were severing residents when it was the number in the table rotation or when a staff member was ready to provided assistance to a resident who required assistance. It was confirmed that the scrambled eggs had the potential to not be a safe consistency for residents on the identified diet.

b) On an identified date during this inspection lunch service was observed in an identified home area. One of the main entrees served was a tuna noodle casserole which included, 10 millimetre (mm) long noodles, tuna chucks and minced onion in a runny sauce that dripped off the fork. Two different textures of the entree were available to the food service worker (FSW) to serve.

The home's policy titled "Mechanical Food Texture Modification Standards, (FS-09-01-15), described the texture of an identified diet texture. The International Dysphagia Diet Standardization Initiative (IDDSI) guidelines described the desired texture of an identified diet texture.

The "Therapeutic Summary" used to provide direction to the FSW severing the food at each meal service said a "tuna noodle casserole, chopped", was to be provided for resident on an identified diet. Residents on the identified diet were observed to be served a regular texture noodle casserole.

Inspector #583 confirmed with FSS #122, serving lunch in the above noted home area and FSW #123 serving lunch in another home area, that no chopped tuna casserole was provided from the kitchen and residents on an identified diet were served a regular textured casserole.
Inspector #583 went to the kitchen and observed the "Macassa Lodge Foodservice Production Sheets – February 25 – March 3, 2019", used to direct the cook how much to prepare and what texture modification was required for each menu item. The production sheet directed the cook to prepare a regular textured tuna noodle casserole for the specified diet textures. In an interview with Food Service Supervisor #115 and #116 at

the time of this inspection, it was confirmed that the cooks were directed to prepare a regular textured tuna casserole for two specified diet textures, that there was no printed recipe available for a third diet texture in the recipe binder used by the cooks and that the information provided on the "Therapeutic Summary" did not match the production sheet.

Inspector #583 asked the FSS's if this was a recent change and if the home had a specific textured recipe in their electronic menu system. It was shared this was not a new change and a recipe was located in the home's electronic menu system titled "Casserole, Tuna Noodle for a specific texture". The recipe stated "For optimal food safety and nutrient retention, texture modification should be done within one hour of service". In an interview with the FSS it was confirmed that the food was prepared a day ahead of time and cooked using a re-therm process on the units.
Residents on the identified diet who received the tuna noodle casserole on the identified date, did not receive a safe diet texture.

c) On an identified date at the time of this inspection, lunch service was observed in an identified home area. For dessert one of the choices was a gelatin dessert. One of the gelatin desserts was served in solid cubed pieces and the other looked like stirred gelatin pieces and was not cohesive or uniform in texture, creating a mixed consistency with pieces of gelatin that could change from solid to liquid. FSW #122 shared they received individually portioned cubed gelatin and a bulk container of stirred gelatin labelled "jello". FSW #122 shared the cubed gelatin was for residents on specified diet textures and the stirred gelatin was for residents on other specific diet textures.

The "Therapeutic Summary" used to provide direction to the FSW stated "Note: ice cream and jello are not allowed on a specified diet texture". There was no direction to identify what alternative dessert was to be served to residents on the specified textured diet. Inspector #583 went to the kitchen and observed the "Macassa Lodge Foodservice Production Sheets – February 25 – March 3, 2019", which directed the kitchen staff to prepare "jello with pureed fruit" for residents on specified diet textures. Inspector #583 could not locate the "jello with pureed fruit" in the recipe binder located in the kitchen. On the third attempt of providing the inspector with a recipe FSS #114 and #115 located the recipe. In an interview with FSW #123 who prepared the "jello with pureed fruit" it was shared they did not follow the recipe on the day it was prepared as they could not locate it and shared when they followed the recipe they were unable to get a smooth cohesive texture as the partially chilled jello did not mix smoothly with the pureed fruit that was added.

In an interview with the Director of Food Services, it was confirmed that there was no direction on the "Therapeutic Summary" used to direct the FSW what residents on the specified diet were to be served as an alternative to the gelatin dessert. It was confirmed that there was not clear direction for the staff serving on an identified date, as the dessert alternative for the cubed jello product sent to the units was only labelled "jello" in a bulk container and the "Therapeutic Summary" said jello was not allowed on for any residents on the specified diet.

It was unable to be confirmed if the "Gelatin, Jellied Fruit specified diet texture" recipe was safe for residents on the specified diet or for residents who could not tolerate the jello. Gelatin pieces had the potential to change from a solid to a thin consistency. Residents on an identified diet or those who could not tolerate mixed consistencies who were served the stirred gelatin product from the bulk container on the identified date, were not served a safe texture.

d) On an identified date in 2019, resident #018's clinical record showed they were assessed by the RD after a referral was sent because the resident had experienced an incident with a texture modified menu item being too dry during meal service on an identified date. Interviews were completed with the FSW staff during the course of the inspection. It was shared the consistency of the texture modified item was not always the desired consistency when small portions were cooked using the re-therm process on the units. The "Macassa Lodge Foodservice Production Sheets – February 25 – March 3, 2019", were reviewed and for the texture modified item that was served on the identified date, it was documented staff were to "add moisture".

An interview was completed with FSW # 129 and #130 who portioned food out using the production sheets in the kitchen. It was identified that the only instruction on the production sheets for multiple modified textured items was "add moisture". It was confirmed that staff did not have direction as to what type of moisture to add, how much moisture to add or if the moisture was to be added before or after the texture modified items were portioned for the units to be cooked in the re-therm system.
In an interview with the FSS #116 it was shared that "add moisture" was added to some items on the production sheet where it had been previously identified the texture modified product had the potential to become too dry after being cooked using the re-therm process.

It was confirmed that there was no clear direction for staff to follow and that all items did not have a standardized recipe that achieved the desired texture . It was identified that

some of the texture modified items had the potential to not be moist or if too much of a liquid was added not a cohesive texture. This created a potential that some modified textures being made using this method had the potential to be an unsafe consistency for residents who required a specific diet. (583) [s. 11. (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 and ensuring that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

In accordance with Ontario Regulation 79/10, s., 2 (1), physical abuse is defined as; the use of physical force by anyone other than a resident that causes physical injury or pain.

In accordance with Ontario Regulation 79/10, s., 2 (1), emotional abuse is defined as; any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

a) The licensee failed to protect resident #003 from physical abuse.
It was confirmed at the time of this inspection, following interviews with Personal Support

Worker (PSW) #118, Registered Practical Nurse (RPN) #128 and a review of resident #003's clinical record, that the following incident occurred:

On an identified date in 2017, RPN #128 requested the assistance of PSW #118 to perform an identified procedure for resident #003. It was identified and documented that when there was an attempt to perform the procedure resident #003 demonstrated resistance to this procedure being performed. PSW #118 restrained the resident in order for the procedure to be done which resulted in resident #003 sustaining an identified injury.

During an interview with resident #003 at the time of this inspection, they acknowledged that they recalled the injury that occurred on the above noted date, that it hurt them and explained why the injury had occurred.

During interviews with RPN #128 and PSW #118, they both acknowledged that the resident's actions demonstrated the resident did not want procedure performed and the resident was capable of giving or withholding consent for such procedures.

The licensee failed to protect resident #003 from physical abuse when PSW #118 inappropriately restrained resident #003 which caused the resident to experience pain and injury, when RPN #128 and PSW #118 failed to respect resident #003's right to refuse consent for a treatment and when RPN #128 failed to appropriately direct PSW #118 in the care for resident #003. (129)

b) The licensee failed to protect resident #008 from physical and emotional abuse.

While completing Critical Incident Inspection #2019_756583_0005, Log # 008034-17 related to Critical Incident Report #M552-000024-17, which was submitted on an identified date in April 2017, regarding an incident of alleged staff to resident abuse that occurred on an identified date, the following was identified:

The home's investigation notes and the resident's clinical records were reviewed. At the time of this inspection neither the resident nor the alleged staff member were able to be interviewed.

As per the home's investigation notes resident #008 told the registered nurse that on an identified date, they had received rough care from PSW #120. Resident #008 shared they required specified care. It was shared that PSW #120 pulled off their clothing

without unbuttoning it. They were then placed on their back and the PSW pointed for the resident to roll over, but did not speak to them. The resident shared they attempted to roll over but were afraid to fall, then the PSW pushed them further and struck them three times on an identified body part. The resident shared at the time of the incident they said ouch and began to cry.

In an interview with resident #008's roommate during the investigation it was shared they heard resident #008 crying which was not usual for the resident and heard PSW #120 say, why are you crying, I'm not hurting you, in a loud voice.

In an interview with the social worker #121 on an identified date in April 2017, resident #008 shared they were crying at the time of the incident and were frightened that they would have to see PSW #120 again. They shared PSW #120 was often rough but that it was worse than usual.

Resident #008 had a specified level of cognitive functioning. In an interview with the DON at the time of this inspection, who was a staff member involved in the investigation, it was confirmed that at the time of the incident, resident #008 had a specified cognitive level and not previously brought any concerns forward related to rough care from staff.

During the investigation, interviews completed by the home with PSW #120 it was confirmed that the staff provided rough care to resident #008.

In an interview with the DON at the time of this inspection, it was confirmed that on the identified date in April 2017, resident #008 received rough care which caused pain and was treated in a manner that was intimidating and showed lack of acknowledgement. (583) [s. 19. (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 and ensuring that the long-term care home protects residents from abuse by any one and shall ensure that residents are not neglected by the licensee or staff , to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24-hour admission care plan included, any risk of falling and interventions to mitigate those risks.

Resident #004 was admitted on an identified date in 2017, and their 24-hour admission care plan did not include an assessment of the risk for falling or interventions to mitigate those risks.

Clinical documentation verified that staff selected generic data on a Falls Risk tool located in the computerized documentation program on the date the resident was admitted to the home, and identified the following generic risks:
-had 2 or more significant falls in the last 3 months
-took one of a group of medications that placed the resident at risk (Vasodilators/Cardiacs),
-had difficulty getting off the toilet/bed/chair and/or tend to make use of towel rails/bedside tables or other furniture or fixtures to assist them in transferring or for additional support while ambulating,
-wore ill-fitting shoes/slippers, high heels and/or shoes with poor grip,
-was incontinent, require frequent toileting or prompting to toilet or require nocturnal toileting,
-food intake declined in the past 3 months due to a loss of appetite, digestive problems, chewing or swallowing difficulties,
-lost or gained weight in the past 3-12 months, and
-had any of the following medical condition\s that affect their balance and mobility (Arthritis, Diabetes, Dementia, Respiratory condition, Parkinson's disease, Cardiac/CVA, etc.)

Clinical documentation confirmed that resident #004 fell 42 days following their admission to the home which resulted in the resident sustaining two identified injuries.

During an interview with Nurse Manager #112 and following a review of clinical information, they confirmed that there was no evidence in the clinical record that there had been an assessment of the above noted generic risk factors or how those factors affected resident #004, a care focus related to falls had not been developed and there were no interventions identified to mitigate the risks for the resident related to falling in the care plan. [s. 24. (2) 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 and ensuring that the 24-hour admission care plan identifies the resident and must include, at a minimum, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of health conditions, including allergies, pain, risk of falls and other special needs.

a) Resident #002's plan of care included a care plan focus related to falls that was created on an identified date in January 2015, initiated on an identified date in October 2016 and last revised on an identified date in October 2016. This care plan focus was not based on an interdisciplinary assessment of the generic risks for falling selected for this resident.

Clinical documentation verified that staff selected generic data on a Falls Risk tool located in the computerized documentation program on an identified date in January 2017, and identified the following generic risks:
- had more than 2 significant falls in the last three months,
- took five or more medications,
- took four categories of medication from a list of 10 categories of medications (Vasodilators/Cardiacs, Analgesics, Antihypertensives and Antidepressants)

-had difficulty getting on and off the toilet/bed/chair and/or tend to make use of towel rails/bedside tables or other furniture or fixtures to assist them transferring or for additional support while ambulating,
- was unsafe/unsteady when asked to stand from a chair, walk three meters, turn and return to the chair independently (using a walking aid if the resident normally walks with an aid),
-was incontinent, they require frequent toileting or prompting to toilet or they require nocturnal toileting,
-experienced Anxiety/Depression, and
-had medical condition/s that affect their balance and mobility (Arthritis, Diabetes, Dementia, Respiratory conditions, Parkinson's disease, Cardiac/CVA, etc.)
The same document completed on an identified date in 2017, indicated that all of the same generic risks had been selected, except the resident had not had more than two significant falls in the last three months.

During an interview with Nurse Manager #112 and following a review of clinical information they confirmed that there was no evidence in the clinical record that there had been an interdisciplinary assessment of the impact of the generic risk factors identified above and resident #002's plan of care was not based on an assessment of the selected factors that place resident #012 at risk for falling.

b) Resident #012's plan of care included a care plan focus related to falls that was initiated on an identified date in August 2013, and last revised on an identified date in May 2015. This care plan focus was not based on an interdisciplinary assessment of generic risk for falling selected for this resident.

Clinical documentation verified that staff selected generic data on a Falls Risk tool located in the computerized documentation program on an identified date in October 2018, and identified the following generic risks:
- had more than 2 significant falls in the last three months,
- took 5 or more medications,
- took medications from the following groups: Analgesics, Antihypertensives, Antiparkinsonian, Diuretics and Antidepressants.
-difficulty getting on and off the toilet/bed/chair and/or tend to make use of towel rails/bedside tables or other furniture or fixtures to assist them transferring or for additional support while ambulating,
- unsafe/unsteady when asked to stand from a chair, walk three meters, turn and return to the chair independently (using a walking aid if the resident normally walks with an aid),

-was incontinent, they require frequent toileting or prompting to toilet or they require nocturnal toileting,
-experienced decreased co-operation, insight or judgement, especially regarding mobility,
-had medical condition/s that affect their balance and mobility (Arthritis, Diabetes, Dementia, Respiratory conditions, Parkinson's disease, Cardiac/CVA, etc.)
-observed behavior in activities of daily living and mobility indicate the resident under-estimates their abilities inappropriately, fear of activity or over-estimates their ability resulting in frequent risk-taking behaviour

The same document completed on an identified date in December 2018, indicated that all of the same generic data had been selected, except the resident had not had more than two significant falls in the last three months and in addition to the above, staff had selected; the resident had uncorrected hearing loss as well as the resident had lost or gained weight in the last three to twelve months.

During an interview with Nurse Manager #112 and following a review of clinical information they confirmed that there was no evidence in the clinical record that there had been an interdisciplinary assessment completed of the impact of the generic risk factors identified above for the resident either following the data collection on the identified date in October 2018, or the data collection on the identified date in December 2018, and resident #012's plan of care was not based on an assessment of the selected factors that place resident #002 at risk for falling. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that were the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

a) Resident #002 was not assessed following a fall the resident experienced on an identified date in September 2018. Staff were alerted by a family member that the resident had struck their head.

The licensee's policy "Fall Management Program", identified as NM-03-02-08 with a reviewed date of September 19, 2018, directed that as part of a fall assessment staff were to initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury. The routine identified in the policy for completing HIR was that monitoring of the resident was to occur every hour for the first four hours and every four hours for 24 hours post fall for signs of neurological changes. The monitoring was to be completed on a white Head Injury Routine form.

During an interview with Nurse Manager #112, they acknowledged that based on information provided by the resident's family, the resident should have been assessed for a potential head injury.

Following a review of documentation they verified that the resident had not been assessed for a head injury when staff did not conduct monitoring of the resident every four hours for the first four hours, every hour for 24 hours after the incident, staff did not complete monitoring for neurological changes, staff did not document on the white Head Injury Routine form and resident #002 was not assessed for a possible head injury when it was identified that the resident had struck their head.

b) Resident #004 was not assessed following a fall the resident experience in February 2017.

The licensee's policy "Fall Management Program", identified as NM-03-02-08 with a reviewed date of September 19, 2018, directed that as part of a fall assessment staff were to initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury. The routine identified in the policy for completing HIR was that monitoring of the resident was to occur every hour for the first four hours and every four hours for 24 hours post fall for signs of neurological changes. The monitoring was to be completed on a white Head Injury Routine form. The policy also directed that, if the resident was on anticoagulant therapy HIR is to be completed regardless of whether fall was witnessed or unwitnessed.

Clinical documentation verified that resident #004 sustained an injury to their head on an identified date in February 2017. At that time clinical documentation indicated the resident complained of pain in an identified location and staff noted the resident had a visible sign of a head injury.

During an interview with the DON, they acknowledged that based on documentation recorded on a Head Injury Assessment form that was initiated at the time of the fall on the identified date, staff had not completed an assessment related to a head injury, when staff did not complete the assessment every four hours for 24 hours after the fall. Documentation indicated that the resident was to be assessed at approximately 1720 hours and then again at approximately 2120 hours on the identified date.

Staff had did completed a head injury assessment of resident #004 when they failed to assess the resident over a 12 hour period of time after the resident had fallen and sustained an identified head injury. [s. 49. (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 and ensuring that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriated assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the license was subject.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD).

The licensee did not comply with the conditions to which the licensee was subject in relation to the completion of the RAP assessment summaries for non-triggered clinical conditions.

1. The MDS Assessment for resident #002 completed on an identified date in December

2017, section J (2, 3 and 4), indicated that the resident experienced pain daily, the intensity of the pain was identified as moderate and the site of pain was identified as "Soft tissue". The Director of Nursing and Unit Manager #119 acknowledged pain was a non-triggered clinical condition, a RAP assessment form was not generated in response to staff coding that the resident experienced pain and the home did not have a process for completing RAP summaries for non-triggered clinical conditions.

The Director of Nursing verified that the completion of a RAP summary had not been documented in the resident's clinical record and acknowledged that RAI-MDS practice standards had not been followed when a RAP summary had not been completed for this non-triggered clinical condition when staff identified that resident #002 had experienced pain during the observation period of the above noted MDS assessment.

2. The MDS Assessment for resident #004 completed on an identified date in January 2017, Section J (2 and 3), indicated the resident experienced pain less than daily, the intensity of the pain was identified as mild and the site of pain was identified as "Other".

The following MDS Assessment identified as a Significant Change Assessment for resident #004, completed on an identified date in March 2017, Section J (2, 3 and 4), indicated the resident experienced pain daily, the intensity of the pain was identified as moderate, the sites of pain were identified as "back and other", the resident had fallen in the past 30 days and the resident had experienced an injury in the past 180 days.

The Director of Nursing and Unit Manager #119 acknowledged pain was a non-triggered clinical condition, a RAP assessment form was not generated in response to staff coding that the resident experienced pain and the home did not have a process for completing RAP summaries for non-triggered clinical conditions. The Director of Nursing verified that the completion of RAP summaries had not been documented in the resident's clinical record and acknowledged that RAI-MDS practice standards had not been followed when RAP summaries had not been completed for this non-triggered clinical condition when staff identified that resident #004 had experienced pain during the observation periods for the MDS coding completed on an identified date in January 2017 or March 2017.

3. The MDS Assessment for resident #012 completed on an identified date in January 2019, Section J (2, 3 and 4), indicated that the resident experienced pain daily, the intensity of the pain was identified as moderate, the sites of pain were identified as "Back, Joint, Other", the resident fell in the past 30 days and fell in the past 31 to 180 days.

The Director of Nursing and Unit Manager #119 acknowledged pain was a non-triggered clinical condition, a RAP assessment form was not generated in response to staff coding that the resident experienced pain and the home did not have a process for completing RAP summaries for non-triggered clinical conditions. The Director of Nursing verified that the completion of a RAP summary had not been documented in the resident's clinical record and acknowledged that RAI-MDS practice standards had not been followed when RAP summaries had not been completed for this non-triggered clinical condition when staff identified that resident #012 had experienced pain during the observation period for the above noted MDS.

The Director of Nursing acknowledged that the RAI-MDS practice standards were not followed when RAP Assessment summaries were not completed for the non-triggered clinical condition of pain, for resident # 002, resident #004 and resident #012. [s. 101. (4)]

Additional Required Actions:

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

WN #8: 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 :

The licensee failed to ensure a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, immediately report reported the suspicion and the information upon which it was based to the Director.

It was verified during an interview with resident #003, during staff interviews and during a review of resident #003's clinical record, that on an identified date in November 2017, RPN #128 attempted to perform a procedure for resident #003, the resident resisted having the procedure performed, PSW #118 restrained resident #003, which resulted in resident experiencing pain and an identified injury.

If was verified during an interview with resident #003, RPN #128 and PSW #118 that at the time of the incident the resident was capable of giving or withholding consent to have the procedure performed.

Following a review of clinical notes, non-clinical notes made of the incident as well as interviews with staff, the following categories of staff were aware of the incident of inappropriate care that resulted in harm to resident #003: the Director of Nursing, Unit Managers, Registered Nurses, Social Worker, Registered Practical Nurses and Personal Support Workers.

At the time of this inspection the Administrator reviewed the home's Critical Incident System logs and verified that the Director was not notified of this incident of improper or incompetent treatment or care of resident #003 that resulted in the resident sustaining an injury and experiencing pain. [s. 24. (1)]

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*

Issued on this 6th day of May, 2019

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

Original report signed by the inspector.