Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

**Division des foyers de soins de longue durée**
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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 2, 2017 | 2017_435621_0019 | 009428-17 | Resident Quality Inspection |

### Licensee/Titulaire de permis

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT MANITOUWADGE ON P0T 2C0

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

MANITOUWADGE GENERAL HOSPITAL
1 HEALTH CARE CRESCENT MANITOUWADGE ON P0T 2C0

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

JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 19 - 23, 2017.**

**During the course of the inspection, the inspector(s) spoke with the Ward Clerk, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD), a Dietary Aide, the Nurse Manager, the Director of Care (DOC), the Administrator, residents and families.**

**The Inspectors observed the delivery of care and services to residents, resident interactions, staff to resident interactions, conducted a tour of the resident home areas, reviewed resident health records, various home policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During resident observations on a day in June 2017, Inspector #621 observed resident #004 with a safety device in place. It was noted by the Inspector that resident #004 was unable to disengage their safety device.

On another day in June 2017, Inspector #621 reviewed resident #004's health record, which identified that this resident's physician ordered a safety device on a specific day in March 2017.

During interviews with RPN #100 and RN #101 on another day in June 2017, RPN #100 reported to Inspector #621 that resident #004 had specific safety device ordered and that it was to be used during specified times. RPN #100 and RN #101 reported that details on the resident's plan of care regarding the use of the safety device could be found on the resident's Kardex.

Inspector #621 reviewed resident #004's Kardex, last revised on a specific day in January 2017, which identified that the safety device was to be used if the resident demonstrated specific behaviours.

During an interview with the Nurse Manager on a subsequent day in June 2017, they reported to Inspector #621 that it was their expectation the written plan of care provided clear directions to staff and others who provide care to the resident regarding resident #004's safety device.

On the same day in June 2017, the Nurse Manager reviewed resident #004's written plan of care and confirmed to the Inspector that information regarding the safety device, which was documented in the Kardex was not consistent with the physician's orders and consequently, the written care plan did not provide clear directions regarding the use of the safety device, and should have. [s. 6. (1) (c)] (621)

2. During a staff interview with Inspector #621 on a specific day in June 2017, resident #004 was identified to have had a significant weight change over a specified period of time.

During a specific activity on a day in June 2017, Inspector #621 observed resident #004 receive a particular diet texture.

During an interview on a subsequent day in June 2017, RN #101 reported to Inspector #621 that staff referred to each resident's Kardex for their diet information.

On the same day in June 2017, Inspector #621 reviewed resident #004's plan of care, including the resident's diet order as documented in their Kardex, a specific section of their care plan, and the physician's orders of their chart. The Inspector identified that the diet order located in resident #004's Kardex, last updated in January 2017, and on the physician's orders, last updated in May 2017, were for a different diet texture than what was observed by Inspector #621 to be offered at a specific meal on the previous day. Additionally, two sections of resident #004's written care plan, last updated on a specific day in June 2017, listed yet another diet texture which was different than what was documented in the resident's Kardex, physician's orders, or what was observed to be offered during the specific activity on the previous day.

On a day in June 2017, the Registered Dietitian (RD) reported to Inspector #621 that they changed resident #004's diet in March 2017, from one specific diet texture to another. The RD confirmed that the documentation found in this resident's plan of care was not consistent with the requested diet texture change they had made in March 2017. The RD subsequently acknowledged that they had not carried through with a request to change the diet order in the physician's orders of this resident's chart in March 2017.

During an interview with Inspector #621 on another day in June 2017, Nurse Manager #102 reported that it was their expectation that the resident's plan of care provide clear directions to staff who provided direct care to the resident. On review of the plan of care for resident #004, they confirmed that there was unclear direction with respect to this resident's diet requirements. [s. 6. (1) (c)] (621)

3. During a staff interview with Inspector #621 on a specific day in June 2017, resident #005 was identified to have had a significant weight change over a specified period of time.

During a specific activity on another day in June 2017, Inspector #621 observed RPN #100 offer resident #005 a specific fluid consistency.

During interviews with RPN #100 and RN #101 on the same day in June 2017, they reported to Inspector #621 that resident #005 required the consistency of their fluids to be altered, but were unsure of the exact consistency since the Food Services staff prepared this resident's fluids prior to meal service. When the Inspector inquired if there were any other times when nursing staff were required to alter a resident's fluid consistency, RPN #100 and RN #101 reported that there were occasions when staff on the unit were required alter the consistency of resident #005's fluid. RN #101 further reported that, in the absence of a diet order for a specified fluid consistency, unit staff had to estimate the volume of a specific food additive to use, and that staff referred to the resident's Kardex for the specific fluid consistency.

On the same day in June 2017, Inspector #621 reviewed resident #005's Kardex and physician's orders which were the most current at the time of inspection, which identified a specific diet texture, but no information on the required fluid texture. Additionally, on review of resident #005's written care plan, last updated on a specified day in March 2017, it identified this resident required a different specific diet texture to what was listed in their Kardex and physician's orders, with no information as to the required fluid texture.

During an interview with the Registered Dietitian (RD) on another day in June 2017, they reported to Inspector #621 that they requested a change to resident #005's diet texture in March 2017.

On the same day in June 2017, the RD reviewed resident #005's Kardex, care plan and diet orders that were in effect at the time of the inspection, and confirmed that this resident's plan of care was not consistent with respect to the requested diet change they made in March 2017. The RD also acknowledged that they had not made a request to change the diet order in the physician's orders of this resident's chart in March 2017. Additionally, the RD acknowledged that they had not requested an order for a specific fluid consistency for this resident.

During an interview with the Nurse Manager on another day in June 2017, they identified to Inspector #621 that it was their expectation that the resident's plan of care provided clear directions to staff who provided direct care to the resident. On review of the plan of care for resident #005, they confirmed that there was unclear direction with respect to this resident's diet requirements. [s. 6. (1) (c)] (621)

4. During a staff interview with Inspector #621 on a specific day in June 2017, resident #006 was identified to have had a significant weight change over a specified period of

time.

During a specific activity on a subsequent day in June 2017, Inspector #621 observed resident #006 receive a specific diet and fluid texture.

During an interview on the same day in June 2017, RN #101 reported to Inspector #621 that staff referred to the resident's Kardex for their diet requirements.

On the same day in June 2017, Inspector #621 reviewed resident #006's plan of care, and identified that the diet order located in resident #006's Kardex, last updated in January 2017, and on the physician's orders, last updated in May 2017, were different than what was documented in another section of resident #006's written care plan, last updated in June 2017.

During an interview with the RD on a specific day in June 2017, they reported to Inspector #621 that they had assessed resident #006 in May 2017, and at that time had changed this resident's diet. On review of resident #006's plan of care, the RD confirmed that diet information that was documented was not consistent with the requested diet change they made in May 2017. The RD also acknowledged that they had not made a written request to change the diet order in the physician's orders of this resident's chart in March 2017, and should have.

During an interview on another day in June 2017, the Nurse Manager identified to Inspector #621 that it was their expectation that the resident's plan of care provided clear directions to staff who provided direct care to the resident. On review of the plan of care for resident #006, they confirmed that there was unclear direction with respect to this resident's current diet requirements. [s. 6. (1) (c)] (621)

***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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, where the Long Term Care Homes Act, 2007, or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that it was complied with.

Ontario Regulation 79/10, s. 49 (1) identifies that the falls preventions and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

On a day in June 2017, during a staff interview, it was identified that resident #003 fell within a specific time period. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) also identified that resident #003 fell within a specific time period of the most recent assessment.

On another day in June 2017, Inspector #625 reviewed the home's policy titled "Falls Prevention Strategies - B-138 LTC", last revised in March 2016. The policy indicated that a "Fall Prevention Assessment" was to be completed quarterly, upon change in a resident's condition and within 24 hours of a fall. The policy identified that all residents displaying a low or high risk of falling, as indicated by the assessment, would have the appropriate falls prevention interventions started. The Inspector then reviewed the home's documents titled "Standard Falls Prevention Interventions" (undated) and "High Risk Fall Prevention Interventions" (undated) that identified the interventions listed for use with residents at low risk of falling, those with multiple fall risk factors and those who had fallen, to reduce the severity of injuries due to falls and to prevent falls from

reoccurring.

During an interview with the Nurse Manager on another day in June 2017, they stated to Inspector #625 that the "Fall Prevention Assessment" referred to in the home's policy was the "Morse Fall Scale".

During interviews with Inspector #625 on the same day in June 2017, RNs #109, #110 and #111 stated that a "Morse Fall Scale" was to be completed after every resident fall.

On a specific day in June 2017, Inspector #625 reviewed resident #003's health care record and identified:
- "Interdisciplinary Progress Notes" for a specified number of dates, which indicated that resident #003 fell on each of those dates; and
- "Morse Fall Scales" which had been completed for only a specific number of the total falls reported, and only one of these was completed within 24 hours of the fall. The Inspector was unable to locate completed "Morse Fall Scales" for the other reported falls that occurred on specific dates from March through May 2017.

On another day in June 2017, Inspector #625 interviewed RN #112 who confirmed resident #003 fell a specific number of times between March and June, 2017. Additionally, RN #112 reviewed the completed "Morse Fall Scales" and acknowledged that, for the falls identified, there were no corresponding "Morse Fall Scales" completed for 71 per cent of the falls. Further, RN #112 stated that staff were to complete a "Morse Fall Scale" after each fall, but had not. [s. 8. (1) (a),s. 8. (1) (b)] (625)

2. Ontario Regulation 79/10, s.68(2)(e)(ii) identifies that the licensee of a long-term care home shall ensure that the nutrition and hydration program included, a weight monitoring system to measure and record with respect to each resident, the body mass index and height upon admission and annually thereafter.

During a census review completed by Inspector #625 on a specific day in June 2017, resident #001 was identified as having a height measurement last completed on a specified day in 2014.

Inspector #625 reviewed resident #001's chart, and electronic health record, which identified a specific height measurement for this resident which was last measured and documented in 2014.

A review of the home's policy titled "Nutrition Care and Hydration – New Resident Admission – B-145", last revised/reviewed April of 2016, identified that "heights and body mass index will be completed upon admission and annually".

Inspector reviewed the Registered Dietitan's (RDs) assessments and weight records from 2012 and 2013 which documented a specific height on the "LTC Weight Records" form, which was different than what had been recorded in the RD's 2015, 2016 and 2017 weight records.

During an interview with the Resident Assessment Instrument (RAI) Coordinator on a specific day in June 2017, they stated to Inspector #625 that the most recent height obtained for resident #001 on the electronic health record was dated in 2014. On the same day, the RAI Coordinator obtained a current height which was different from the 2014 measurement, and provided this information to the Inspector.

During an interview with Inspector #625 on another day in June 2017, the RD acknowledged that they had not obtained a height measurement for resident #001 since they had been employed in their position in August of 2016.

During an interview with Inspector #625 on the same day in June 2017, the Nurse Manager stated that height measurements had not been taken annually by nursing staff. Nurse Manager #105 reviewed the home's electronic health record with Inspector #625 and acknowledged that the height listed on resident #001's profile was last taken in 2014, but that resident height should have been taken on admission and then annually. [s. 8. (1) (b)] (621)

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that, when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On a specific day in June 2017, during a staff interview, it was identified to Inspector #625 that resident #003 fell over a specified time period.

On another day in June 2017, Inspector #625 reviewed resident #003's health care record which identified a specific day and time in March 2017, where this resident had fallen and sustained an injury. The Inspector however, was not able to locate a post-fall assessment, using a clinically appropriate assessment instrument that was specifically designed for falls for this incident.

During an interview with the Nurse Manager on another day in June 2017, they stated to Inspector #625 that the home had no formal post-fall assessment for staff to complete after a fall, that staff would instead take direction from the physician's orders for what assessment to complete, and that further documentation would be recorded in the "Interdisciplinary Progress Notes".

During an interview with the Director of Care (DOC) on the same day in June 2017, they stated that staff were required to contact the physician after a resident fell and that the home had no clinically appropriate assessment instrument specifically designed to assess residents after falling. [s. 49. (2)] (625)

***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 falls, the resident is assessed and that where the condition or circumstances of the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Inspector #625 reviewed resident #001's most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS), which identified that this resident had had altered skin

integrity.

Inspector #625 reviewed resident #001's health care record including:
- "Weekly Wound Assessments" completed between specific dates in December 2016, and June 2017, which identified altered skin integrity present; and
- "Interdisciplinary Progress Notes" from a specified number of days in March 2017, which indicated altered skin integrity.

On further review of the documentation, Inspector #625 was unable to locate a clinically appropriate assessment instrument, specifically designed for skin and wound assessments, which had been completed for resident #001's documented altered skin integrity.

During an interview with Inspector #625 on a specific day in June 2017, RN #109 stated that resident #001 currently had altered skin integrity. The RN further stated that the treatment plan for resident #001's altered skin integrity included use of a prescription medication that was ordered for application over a specific time frame, in addition to the use of other specified treatments.

During interviews with Inspector #625 on a day in June 2017, RNs #109 and #110 stated that there was no clinically appropriate assessment instrument used by the home that was specifically designed for skin and wound assessments. RNs #109 and #110 further stated that when staff completed an assessment of altered skin integrity, that it was documented in the "Interdisciplinary Progress Notes".

During an interview with the Nurse Manager on the same day in June 2017, they stated to Inspector #625 that the home used a "Wound Management Flow Chart" as their clinical assessment instrument for skin and wounds. The Nurse Manager also reported that a "Wound Management Flow Chart" should have been initiated with each altered skin integrity issue identified, and that this document should have been kept in the resident's chart and maintained for each wound identified, until each wound was healed. The Nurse Manager acknowledged that some of the resident charts did not have the required "Wound Management Flow Charts" and that resident #001 specifically did not have this document in their chart. The Nurse Manager also indicated that the home could not locate any "Wound Management Flow Charts" for resident #001 in their archived health care record. [s. 50. (2) (b) (i)] (625)

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration were implemented.

Inspector #625 reviewed resident #001's most current Resident Assessment Instrument-Minimum Data Set (RAI-MDS), which identified that this resident had altered skin integrity.

On a specific day in June 2017, Inspector #625 reviewed resident #001’s health care record including:
- “Weekly Wound Assessments” completed between a specific day in December 2016, and June 2017, which identified resident #001 had altered skin integrity.
- Interdisciplinary progress notes dated for a specific number of days in March 2017, which indicated that resident #001 had altered skin integrity present; and
- Physician’s orders for a specified number of prescription medications that were to be used at specific times since they were ordered in the fall of 2016.

A review of the home’s policy titled "Risk Assessment - Skin and Wound Management - 1200", last reviewed/revised April 2016, identified that the treatment for each resident with altered skin integrity was to be developed in consultation with, at a minimum, specifically identified participants including the Registered Dietitian (RD).

During an interview with Inspector #625 on a day in June 2017, the RD stated that they had not received a referral to assess resident #001 for altered skin integrity, during the period of time where impairments and alterations in resident #001’s skin integrity were documented in their health care record. [s. 50. (2) (b) (iii)] (625)

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

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that they consulted regularly with the Residents' Council and Family Council, if any, and in any case that the Councils were consulted with at least every three months.

During interviews on a day in June 2017, resident #002, who was an active member of Residents' Council and Family Council member #113 reported to Inspector #621 that the home's management staff had not consulted with Residents' or Family Councils, at least every three months over the previous year.

On the same day in June 2017, Inspector #621 reviewed copies of Residents' and Family Councils' meeting minutes over the previous 12 months, which documented that representatives of the licensee were present only once at the July 2016, for Residents' Council, and at the September 2016 meeting of Family Council.

During an interview in June 2017, Activity Coordinator #106, who served as the Assistant to both Residents' and Family Councils, reported to Inspector #621 that the Director of Care (DOC) had not consulted with either the Residents' or Family Councils at least every three months.

During an interview on a subsequent day in June 2017, the DOC confirmed to Inspector #621 that they had not consulted with Residents' or Family Councils at least every three months, as per legislative requirements. [s. 67.] (621)

***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 they consult regularly with the Residents' Council and Family Council, if any, and in any case that the Councils are consulted with at least every three months, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

**1. A change of 5 per cent of body weight, or more, over one month.**
**2. A change of 7.5 per cent of body weight, or more, over three months.**
**3. A change of 10 per cent of body weight, or more, over 6 months.**
**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents that had a weight change of 5 per cent body weight, or more, over one month, a change of 7.5 per cent body weight, or more over three months, or a change of 10 per cent of body weight, or more, over six months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

On a day in June 2017, during a census record review completed by Inspector #625, resident #004 was identified to have had a significant weight change. Inspector #621 further reviewed resident #004's weight record, which indicated that for a specific time period in the spring of 2017, there was a significant weight change. Additionally, the Inspector reviewed resident #004's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the significant weight change.

During interviews on a specific day in June 2017, RN #101, RN #109 and Resident Assessment Instrument (RAI) Coordinator #105, reported to Inspector #621 that residents were weighed on the first Tuesday of each month by the RN, RPN or PSW staff, and weights were recorded on the "Long Term Care Monthly Vitals Assessment" form kept in each resident's chart. RN's #101, #109 and RAI Coordinator #105 indicated to the Inspector that there was no formal referral process or policy to direct staff on how to monitor resident's for a significant weight change, when to re-weigh residents for potential weight errors, or when to refer a resident to the RD, except on a resident's admission, when a referral would automatically be generated to notify the RD of the new

admission. RN #101 further identified that if they suspected through clinical observation that there was a large weight change, they would call the RD, but confirmed that they were unable to verify that a referral to the RD had been made to assess resident #004's significant weight change.

In an interview on another day in June 2017, the RD confirmed to Inspector #621 that resident #004 had a significant weight change during a specific time period in the spring of 2017. Additionally, the RD identified that they had not received a referral from the registered nursing staff to assess the significant weight change.

During an interview on a subsequent day in June 2017, Nurse Manager #102 confirmed to Inspector #621 that the home did not have a weight monitoring policy in place to assist staff in identifying significant weight changes at the time weights were taken, and that registered nursing staff were not communicating significant weight changes using an interdisciplinary referral process to the RD, and should have been. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (621)

2. On a day in June 2017, during a census record review completed by Inspector #625, resident #005 was identified to have had a significant weight change. Inspector #621 further reviewed resident #005's weight record, which identified that for a specific time period in the summer of 2017, there was a significant weight change. Additionally, the Inspector reviewed resident #005's health record and was unable to find documentation identifying that a referral to the Registered Dietitian (RD) had been made for the significant weight change.

During an interview on another day in June 2017, RN #101 confirmed to Inspector #621 that they were unable to verify that a referral to the RD had been made for resident #005's significant weight change that was documented over a specific time period in the summer of 2017.

In an interview on a subsequent day in June 2017, the RD confirmed to Inspector #621 that resident #005 had a significant weight change over a specific time period in the summer of 2017. Additionally, the RD identified that they had not received a referral from the registered nursing staff to assess the significant weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (621)

3. On a day in June 20, 2017, during a census record review completed by Inspector #625, resident #006 was identified to have had a significant weight change. Inspector

#621 further reviewed resident #006's weight record, which identified that for a specific time period, in the spring of 2017, there was a significant weight change. Additionally, the Inspector reviewed resident #006's health record and found no documentation that a referral to the Registered Dietitian (RD) had been made for the significant weight change.

During an interview on another day in June 2017, RN #101 confirmed to Inspector #621 that they were unable to verify that a referral to the RD had been made for resident #006's specific weight change that occurred in the spring of 2017.

In an interview on a subsequent day in June 2017, the RD confirmed to Inspector #621 that resident #006 had a significant weight change over a specific time period in the spring of 2017. Additionally, the RD identified that they had not received a referral from the registered nursing staff to assess the significant weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (621)

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents that have a weight change of 5 per cent body weight, or more, over one month, a change of 7.5 per cent body weight, or more over three months, and a change of 10 per cent of body weight, or more, over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

**Specifically failed to comply with the following:**

**s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004, entered into between the licensee and a local health integration network (LHIN), was communicated in a manner that complied with any requirements that were provided for in the regulations.

During a review of the completed Admission Process Long-Term Care Home Licensee Confirmation Checklist on a day in June 2017, Inspector #621 identified that the Nurse Manager had checked off that the home did not have a copy of the licensee's service accountability agreement posted in the home.

During an interview with the Administrator on the same day in June 2017, they reported to Inspector #621 that regarding the Elderly Capital Assistance Program (ELDCAP) funding for the home's EldCap beds, the licensee had a hospital service accountability agreement (HSAA) with the LHIN, and not a separate long-term care service accountability agreement (LSAA).

During an interview on a subsequent day in June 2017, the Director of Care (DOC) and the Nurse Manager confirmed to Inspector's #621 and #625 that the licensee had a copy of its most recent service hospital service accountability agreement (HSAA) between itself and the North West Local Health Integrated Network, but that it had not been posted in the home. [s. 79. (1)] (621)

***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 a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004, entered into between the licensee and a local health integration network (LHIN), is communicated in a manner that complies with any requirements that are provided for in the regulations, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (4) The licensee shall ensure that,**
**(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).**
**(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).**
**(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).**
**(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home documented and made available to the Residents' Council, the results of the satisfaction survey, in order to seek the advice of the Council about the survey.

During interviews on a day in June 2017, resident #002, who was an active member of the Residents' Council reported to Inspector #621 that, to their knowledge, the home had not made available the results of the annual satisfaction survey during the previous year.

On another day in June 2017, Inspector #621 reviewed copies of the Residents' Council meeting minutes over the previous 12 months. The Inspector found no documentation identifying that results of the home's annual satisfaction survey were made available to Residents' Council in order to seek their advice about the survey.

During an interview on a subsequent day in June 2017, Activity Coordinator #106, who had served as the Assistant to Residents' Council since May 2016, reported to Inspector #621 that the Director of Care (DOC) or designate of the licensee had not met with Residents' Council over the previous year to provide results of the annual satisfaction survey, and to obtain the Council's advice about the survey.

During an interview on a specific day in June 2017, the DOC identified to Inspector #621 that they had met with Residents' Council in March 2016 to review the annual satisfaction survey before it was completed, but confirmed that they had not followed up with the Residents' Council thereafter, to review the results of the survey and to obtain their advice, as per legislative requirements. [s. 85. (4) (a)] (621)

***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 home documents and makes available to the Residents' Council, the results of the satisfaction survey, in order to seek the advice of the Council about the survey, to be implemented voluntarily.***

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**WN #9: 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. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including all assessments, reassessments and monitoring, and the resident's response.

On a day in June 2017, Inspector #621 observed resident #004, in their mobility aid with a safety device functioning as a potential restraint.

On a another day in June 2017, Inspector #621 completed a review of resident #004's health record, which identified that this resident's physician ordered the use of a safety device as a restraint on a specific day in March 2017. The order indicated that the restraint was to be used at a specific time and that staff were to document the use of the restraint on the home's restraint monitoring record. The Inspector however, was unable to locate any record with regards to the use of this resident's restraint after the order was made by the physician in March 2017.

During an interview with RPN #100 on another day in June 2017, they reported to Inspector #621 that resident #004 had a specific restraint and that when the restraint was engaged, staff were to monitor, assess and take certain actions with the resident at specific time intervals. When the Inspector asked where registered and non-registered staff kept record of completing specific activities with regards to this resident's restraint, RPN #100 and RN #101 reported that this information was to be documented on the home's restraint monitoring record, which was kept in resident #004's chart.

On the same day in June 2017, RPN #100 and RN #102 reported to the Inspector that no restraint monitoring record had been completed for resident #004's restraint since it was ordered in March 2017, and that it should have been.

During an interview on a subsequent day in June 2017, Nurse Manager #102 reported to Inspector #621 that it was their expectation for all restraints ordered, that restraint assessment, reassessment and monitoring, as required by legislation, was documented on the "LTC Physical Restraint Monitoring Record", and that this information was to be kept in the resident's chart. [s. 110. (7) 6.] (621)

***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 every use of a physical device to restrain a resident under section 31 of the Act is documented, including all assessments, reassessments and monitoring, and the resident's response, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**
**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**
**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**
**2. The system must be ongoing and interdisciplinary.**
**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.**
**4. A record must be maintained by the licensee setting out,**
**i. the matters referred to in paragraph 3,**
**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**
**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods, as required under section 84 of the Act, were communicated to the Residents’ and Family Councils on an ongoing basis.

During interviews on a day in June 2017, resident #002, (who was an active member of Residents' Council), and Family Council member #113 reported to Inspector #621 that the home’s management staff had not communicated improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents as part of the home’s quality improvement and utilization review system, to their knowledge, over the previous year.

On the same day in June 2017, Inspector #621 reviewed copies of the Residents’ and Family Councils' meeting minutes from the previous year. The Inspector found no documentation identifying that improvements made as part of the home’s quality improvement and utilization review system were communicated to either Residents’ or Family Councils.

During an interview on another day in June 2017, Activity Coordinator #106, who served as the Assistant to both Residents’ and Family Councils, reported to Inspector #621 that the Director of Care (DOC) or a designate of the licensee, had not met with either Council to communicate home improvements made under the quality improvement and utilization review system over the previous year.

During an interview on a subsequent day in June 2017, the DOC confirmed to Inspector #621 that they had not communicated with Residents’ or Family Councils over the previous year, improvements that were made as part of the home’s quality improvement and utilization review system, as per legislative requirements. [s. 228. 3.] (621)

***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 improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods, as required under section 84 of the Act, is communicated to the Residents' and Family Councils on an ongoing basis, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident or the resident's substitute decision-maker, if any.

On a day in June 2017, Inspector #625 reviewed the home's most recent "Medication Incident Reports". During this review, a "Medication Incident Report" dated from the summer of 2016, involved resident #007 and an error in the provision of a prescribed medication. A second "Medication Incident Report" dated in the winter of 2016, involved resident #008 and the administration of another prescribed medication different than what was recorded in the physician's order. Neither medication incident report identified

that these residents and/or their substitute decision-makers (SDMs) were notified.

On two specific days in June 2017, Inspector #625 reviewed resident #007 and #008's health care records, with a focus on the medication incidents which had occurred in the summer and winter of 2016 respectively. Neither health care record identified that any medication error had occurred on these dates, if actions were taken with respect to each medication error, or that resident #007 and #008 and/or SDMs were notified.

During an interview with RPN #100 on a specific day in June 2017, they stated to Inspector #625 that they had been involved with both medication incidents. RPN #100 stated that they could not recall if they had notified resident #007 or their SDM, but that any action taken would have been noted in a specific section of the electronic medical record (EMR). RPN #100 also stated that they did not notify resident #008 or their SDM, and did not know who would have, but that in a specific area of the EMR would have identified the actions taken. Upon review of resident #008's EMR, RPN #100 acknowledged that there were no entries related to the medication incident, follow-up action, or resident/SDM notification.

On a subsequent day in July 2017, Inspector #625 interviewed resident #008 and their family member #113. Both indicated that they had not been informed of the medication error that had occurred in the winter of 2016, and the resident stated that they would recall if they had been informed of the incident.

During interviews with Inspector #625 on two specific days in June 2017, Nurse Manager #102 stated that if there was no record that resident #007, #008 or their SDMs were notified, that notification had not occurred. Nurse Manager #102 stated that residents and/or their SDMs should have been notified of the medication incidents. [s. 135. (1)] (625)

**Issued on this 11th day of August, 2017**

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

**Original report signed by the inspector.**