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
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 6, 2017	2017_505103_0007	002744-17	Resident Quality Inspection

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49 R R 2 PICTON ON K0K 2T0

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

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49 HALLOWELL TOWNSHIP PICTON ON K0K 2T0

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

DARLENE MURPHY (103), HEATH HEFFERNAN (622), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8-10, 13-17, 21-22, 2017

The following intakes were included as a part of this inspection:
Log #000728-17 (alleged staff to resident abuse),
Log #030186-16 (alleged staff to resident abuse),
Log #034503-16 (resident fall).

During the course of the inspection, the inspector(s) spoke with residents, the Resident Council President, the Family Council president, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), dietary aides, the Nutritional Services Manager (NSM), the Dietitian, the Resident Services Manager (RSM), an Environmental Services worker , the Environmental Services Manager (ESM), a Physiotherapy assistant (PTA), the Physiotherapist (PT), the Office Manager, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspectors conducted a full walking tour of the home, observed dining service, medication administration and infection control practices, reviewed resident health care records, applicable home policies and the resident and family council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The following non-compliance is related to Log #030186-16:

The licensee has failed to ensure the care set out in resident #041's plan of care was

provided to the resident as specified in the plan.

On an identified date, the home submitted a critical incident to report an alleged staff to resident abuse. The critical incident indicated that on the evening of an identified date, resident #041 had been approached by PSW #127 at approximately 1900 hour and insisted the resident get ready for bed. Resident #041 told the PSW they did not want to go to bed that early. The PSW responded by becoming angry with the resident and threatened that she would "report them to the nurse". In addition, the PSW refused to apply the resident's medicated creams and when asked by the resident to hang up the resident's sweater, the PSW put it on the floor in the corner of the resident's room.

Resident #041's health care record was reviewed in regards to this incident. The resident's plan of care was reviewed and indicated the following:
Under "Bedtime routine":
-resident requests to retire between 2130 and 2200 hour to allow time to enjoy the evening nourishment, watch favourite tv programs, enjoy social time if activities are going on.
-may request an earlier bed time if tired, resident request to retire should be respected.

Under "Dressing":
-requires staff assistance
-provide constant supervision and assistance.

The resident electronic Treatment Administration Record (TAR) indicated the following: Four identified medicated creams that were required to be applied at bedtime.

In an interview with PSW #107, she confirmed the PSWs were responsible for applying the medicated ointments as outlined above.
The home failed to provide the care for resident #041 as outlined in the resident plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in resident #027's plan of care was provided to the resident as specified in the plan.

A review of the electronic progress notes made on identified dates indicated resident #027 had unwitnessed falls in the room during the night.

Review of resident #027's most recent care plan indicated the following:

-impaired ability to transfer related to limited mobility,
-able to transfer self independently but was high risk for falls,
-required a personal alarm when in bed for safety.

During interviews with inspector #622 on February 14, 2017 and February 15, 2017, PSW #113 stated she was resident #027's PSW working on the night the resident fell. PSW #113 stated that resident #027 did not have a personal bed alarm when the resident fell. PSW #113 stated there was a shortage of personal bed alarms and the resident's personal bed alarm was borrowed for resident #030 who was a higher risk for falls.

During an interview with inspector #622 on February 14, 2016, RPN #111 stated she was aware of a time that resident #027's personal bed alarm was borrowed for another resident #030 as there were no other personal alarms available in the home.

During an interview with inspector #622 on February 14, 2017, RN #106 indicated she was aware of times when resident #027 had the personal bed alarm taken for another resident who was considered at higher risk for falls. RN #106 stated there was a shortage of working personal bed alarms and the home had been short for a while. Further interview with RN #106 revealed it was normal practice for staff to borrow a personal bed alarm from one resident to another when the home was short.

During an interview with inspector #622 on February 14, 2017, the DOC stated every shift is required to ensure resident bed alarms are in place as required in the resident plans of care.

The licensee failed to ensure the care set out in the plan of care was provided to resident #027 related to the use of a personal/bed alarm as specified in the plan. [s. 6. (7)]

3. The following non-compliance is related to Log #000728-16:

The licensee has failed to ensure the care set out in resident #042's plan of care was provided to the resident as specified in the plan.

Resident #042 was admitted to the home on an identified date and had identified diagnoses. On an identified date, RPN #114 attempted to give resident #042 an enema following reports that the resident had no bowel movement in the past four days. The resident's family member was visiting at the time and was asked to step out of the room.

During the procedure, the resident became agitated and began yelling and attempted to strike out at the staff member. Two additional staff members assisted by holding the resident's hands to avoid the RPN from becoming struck, but the enema was not successfully given. The family member overheard the yelling and re-entered the resident's room. Resident #042 was observed to be distraught and blamed the family member for the incident. The family member was upset by this incident and reported it to additional family members who in turn contacted the home to express their concerns.

Resident #042's health care record was reviewed and indicated the following:
Under "Resistant to treatment/care", the plan of care, in effect at the time of this incident, indicated,
-may be resistive with care; may require re-approach,
-if resident is not receptive to care, provide space and re-approach 10-15 minutes later. If no success, properly document and report to the registered staff,
-recognize that all aspects of care can be invasive and try to modify your approach to meet the resident's requirements.
-document incidents of resistance and interventions taken to possibly resolve and promote better acceptance to the care.

In an interview with the DOC, she indicated RPN #114 had discussed the incident with her the following day and self identified that she should have left the resident when they resisted the care and returned later. The staff member failed to leave and re-approach in 10-15 minutes as outlined in the resident plan of care when the resident demonstrated resistance. As a result, the residents' behavior escalated causing distress to both the resident and the residents' family. [s. 6. (7)]

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 all aspects of the resident plans of care are provided to the resident as outlined in the plan including bed alarms, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On February 08, 2017 at 0958 hours during the initial tour of the home, inspector #622 observed the female staff room located on the main corridor across from the main dining room was unlocked. On February 08, 2017, inspector #103 observed the staff break room door located off the large resident activity room was not locked. The staff break room was noted to contain access to an outside door.

Both doors were observed to have no locking mechanisms on the outside of the doors and both remained accessible throughout the inspection period even when left unsupervised by staff. Neither areas were equipped with a call bell system and during an interview with inspector #622, ESW #119 stated both the female staff room door in the main corridor and the staff break room door off the large resident activity room were considered non-residential areas.

The Administrator was interviewed by inspector #103. She indicated the home had not previously identified these doors as requiring locks, but agreed both areas were non-residential areas and that a locking mechanism for both doors would be installed. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #3: 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 :

1. The following non-compliance is related to Log #030186-16:

The licensee has failed to ensure an alleged abuse was immediately reported to the Director (MOHLTC).

As outlined in WN #3, an incident of alleged staff to resident abuse occurred on an identified date involving resident #041 and PSW #127. PSW #107 was interviewed and indicated she worked the day shift following the alleged incident and cared for resident #041. The PSW stated that while assisting the resident to get ready for the day, resident

#041 had mentioned she was unhappy with the PSW who had assisted them on the previous evening. PSW #107 indicated the resident did not provide any specifics at that time. S#107 stated that after lunch, the resident appeared to be fearful and expressed worry over the incident the previous evening. The PSW indicated she asked the resident for specifics and it was at that time the resident indicated the PSW had forced them to go to bed and kept entering and exiting the resident's room. The PSW described that at one point, the PSW placed her hands on either side of the resident's face and told the resident they were a problem and would be asking management to remove them from the home. The PSW stated the resident also indicated the PSW refused to assist with the bedtime ointments and had thrown the resident's sweater on the floor in the corner when asked to hang it up. PSW #107 stated she had never seen the resident this fearful and that the resident had expressed worry that the same PSW would be providing care to them again. PSW #107 stated she reported the incident immediately to RN #106 who then proceeded to speak with resident #041.

RN #106 was interviewed and confirmed the resident had relayed the same information to her. The RN stated she had never seen this level of fear before with this resident. RN #106 stated the conversation had occurred with resident #041 on or about 1400 hour as she recalled PSW #107 was just completing her shift. RN #106 indicated she reported the incident to the Director of Care following her discussion with the resident on or about 1545 hour.

The Administrator was interviewed and indicated at the time of this incident, she was the Director of Care in the home. She confirmed RN #106 had reported the alleged incident of staff to resident abuse as outlined above. She stated, upon being made aware of the incident, she checked the schedule to ensure PSW #107 was not working and then contacted the PSW to place them on a paid suspension. The Administrator then indicated she spoke with resident #041 to reassure them that they were safe, the home would be investigating the incident and that the PSW would no longer be providing care to them.

The Administrator indicated the MOHLTC was notified of the alleged staff to resident abuse for the first time by means of the critical incident submission on an identified date approximately twenty four hours after being made aware of the alleged incident of abuse. As a result of the incident, S#127 was terminated from the home. [s. 24. (1)]

2. The following non-compliance is related to Log #000728-16:

The licensee has failed to ensure an incident of alleged staff to resident abuse was

immediately reported to the Director (MOHLTC).

As outlined in WN #3, an incident of alleged abuse occurred on an identified date involving resident #042 and RPN #114. RN #100 was interviewed and indicated she had received a phone call from the resident #042's family member the following day. The RN indicated the family member had stated another family member had been extremely upset by what they had witnessed and that they believed the incident constituted resident abuse. The RN stated she reported the allegations made to the DOC following this call, but later indicated she did not report it.

The Director of Care was interviewed and confirmed RN #100 had not reported the telephone call to her whereby the family member of resident #042 alleged the incident was abusive. She stated the family member did contact the DOC by phone two days following the alleged incident and that a meeting to discuss the incident was arranged at that time.

The Director (MOHLTC) was notified of the alleged staff to resident abuse for the first time by means of a critical incident which was submitted by the home six days following the phone call that alleged staff to resident abuse. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all alleged, suspected or witnessed incidents of resident abuse are immediately reported to the Director (MOHLTC), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #030's front locking seat belt was included in the residents' plan of care.

On February 09 and February 14, 2017, inspector #622 observed resident #030 sitting in the wheelchair with a front locking seat belt in place. On February 09, 2017 the front locking seat belt was noted to be loosely fitted such that inspector #622 was able to place two hands side on side between the resident's abdomen and the front locking seat belt.

On February 15, 2017, PSW #124 was interviewed and indicated the resident had been using the seat belt since they returned from hospital with an identified injury.

On February 15, 2017, RPN #125 was interviewed and stated that resident #030 did not have an order for a front locking seat belt restraint. She indicated the resident was able to undo the belt and therefore no order or consent would be required.

On February 15, 2017 at 1609 hours, inspector #622 assessed resident #030's ability to undo the front locking seat belt. Resident #030 was unable to follow the inspector's direction to open the seat belt. PSW #126 advised the inspector that resident #030 could remove the belt, proceeded to instruct the resident to remove it, but the resident was unable to comply.

Resident #030's plan of care was reviewed. The front locking seat belt was not included in the plan of care and there was no evidence of a physician's order or consent.

During an interview with inspector #622 on February 16, 2017, the DOC stated she requested a review of all residents in the home using a restraint or assistive device. The DOC stated that resident #030 was not identified to her during the review as using a seat belt restraint. The DOC stated that resident #030 should not be using a seat belt restraint as they do not have an order or consent for the restraint. [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident #030's front locking seat belt, if required as a fall prevention intervention, is included in the plan of care, to be implemented voluntarily.

WN #5: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program are readily available at the home.

As outlined in WN #3, resident #027 had a fall on an identified date and according to the resident's plan of care in effect at that time, should have had a personal bed alarm in place as a fall prevention intervention. Staff interviews indicated the home frequently borrowed bed alarms from one resident to another, and the home was chronically short of adequate bed alarms for all residents who required them.

During an interview with inspector #622 on February 15, 2017, the DOC indicated it was the responsibility of the RN's to assess and apply the personal bed alarms which are stored in the nurse's station on second floor. The DOC further stated that the home did not have any extra personal bed alarm systems available.

The licensee failed to ensure that the personal bed alarm for resident #027 under the falls prevention and management program was readily available at the home. [s. 49. (3)]

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 there is a sufficient on-site supply of bed alarms for all residents who require a bed alarm in accordance with their fall prevention interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The following finding relates to Log #000728-17:

The licensee has failed to ensure the continence care and bowel management program provide treatments and interventions to prevent constipation, including nutrition and hydration protocols.

RN's #100 and #106 were interviewed in regards to the home's current method of managing constipation. Both of the RN's reported the home uses the medical directives to manage constipation. Neither RN was aware of any nutritional or hydration protocols in place to address constipation.

The Medical Directives were reviewed and indicated the following:
-Milk of Magnesia (MOM), 30 millilters (mls) every two days as needed to stimulate bowel movements,
-Dulcolax suppository, one inserted rectally every four days if no bowel movement, and
-Fleet Enema, one inserted rectally every four days if no bowel movement.

Both RN's indicated, a resident would be given the MOM first and then if no success, a suppository or enema would then be given. The RN's did state an enema or suppository may be used if the resident refused the MOM.

Resident #042's bowel record was reviewed for an identified period of time. According to this record, the resident had no documented bowel movement (BM) for a period of ten days.

On an identified date, staff documented MOM was given to resident #042 with an unknown effect. On an identified date, (day 5 with no documented BM), the staff charted the resident refused to take MOM and no additional interventions to promote a BM were noted. On a second identified date (day 6 with no documented BM), the staff documented the resident refused "laxative". On a subsequent identified date (day 8 with no documented BM), a fleet enema was attempted but unsuccessful due to the resident becoming resistive/agitated. On day 9 with no bowel movement, the resident was prescribed a medication to be taken orally to promote a BM and on day ten, the staff documented the resident had a BM. Throughout this period of time, there was no evidence that an abdominal assessment was completed or that any nutritional interventions were implemented.

PSW #113 was interviewed and indicated resident #042 was prone to constipation. The PSW stated the resident often refused to take laxatives by mouth and could become agitated and resistant to enemas or suppositories. The PSW stated they used to get prunes sent from the kitchen for the residents to use, but that this had not been done in a long time. The PSW stated she was unaware of any nutritional or hydration interventions in place to manage residents that were prone to constipation.

The Nutritional Services Manager (NSM) #118 was interviewed in regards to nutritional and hydration protocols to reduce constipation. He indicated the home no longer provides prunes for the residents, but uses orange and apple juices to promote bowel regularity. He stated residents can request these juices at any time, but there was no specific protocol in place to address constipation. The NSM was asked how residents with cognitive impairments would be assessed for interventions to reduce constipation and he stated the registered staff would be involved in that process. The NSM did not believe the previous dietitian had any involvement in this area.

A dietary assessment dated with an identified date and completed by the NSM for resident #042 indicated the resident was a low dietary risk, and under "BM" indicated the

resident had regular BM's and current interventions were effective. The NSM stated he was unaware of any issues related to constipation for resident #042.

The current dietitian in the home was not interviewed in regards to this issue as she had been newly hired in the home.

The DOC was interviewed and indicated she had already identified that the home appeared to be utilizing a large number of enemas as a means of managing bowel constipation. The DOC indicated there is no bowel protocol currently in the home to manage constipation using a nutritional approach. She indicated she has provided the "eat and go" cookie recipe to the home and has had some discussion with the home's physician in preparation of developing a more natural protocol. [s. 51. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the bowel management program provides treatments and interventions to prevent constipation including nutrition and hydration protocols, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee has failed to develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents in the long-term care home.

In accordance with O. Reg 79/10, s. 228 this system must include the following:

1. There must be a written description of the system that includes 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 Resident's 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.

On February 9, 2017, the Resident Services Manager (RSM) completed the Quality Improvement LTCH Licensee Confirmation Checklist for Quality Improvement that is required to be completed during the Resident Quality Inspection. The form indicated negative responses to the following questions:
-the licensee has developed and implemented a quality improvement (QI) and utilization review system that monitors, analyses, evaluates and improves the quality of the care services, accommodation, programs and goods provided to residents,
-the QI system is ongoing, interdisciplinary and provides a written description of its goals, objectives, policies, procedures and protocols, and a process to identify initiatives for review,
-the licensee communicates improvements made to the quality of care services, programs, accommodation and goods to the Residents' Council, Family Council and staff in the home,
-the licensee maintains a record of the improvements made to the quality of the accommodation, care, services, programs and goods provided to residents;
- the licensee maintains a record of the names of the persons who participated in evaluations and the dates improvements were implemented and,
-the licensee maintains a record of the communication made to the Residents' Council, Family Council and the staff of the home regarding the improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents.

During this inspection, it was noted that the home's continence care and bowel management program (a required program) does not have a written description that includes goals and objectives and the program is not currently evaluated annually.

On February 16, 2017 during an interview with the Administration, she confirmed at this

time the home does not have a functioning QI program and that it has been inactive since 2014/2015. She indicated the home has had one meeting in January 2017 to discuss getting the QI program in place as well the home's upcoming Accreditation (November 2017). She confirmed the home will be meeting soon to discuss the QI program's goals and objectives.

The Resident Services Manager confirmed the meeting to discuss the continuous quality improvement program and to develop goals and objectives is scheduled for February 22, 2017. [s. 84.]

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 a quality improvement and review system is developed and implemented in the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The following finding relates to Log #000728-17:

The licensee has failed to ensure the continence care and bowel management program has been evaluated and updated at least annually.

O. Reg 79/10, s. 48 (1) 3 identifies continence care and bowel management as a required program. As outlined in O. Reg 79/10, s. 30 (1) 3, every licensee of a long-term care home shall ensure each of the organized programs required under section 48 of the regulations will be evaluated and updated at least annually.

The DOC was interviewed and indicated the continence care and bowel management program currently has no goals or objectives and has not been evaluated or updated in the past several years. [s. 30. (1) 3.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

On February 9, 2017, Inspector #103 observed resident #021 sitting in a tilt wheelchair with a lap belt in place. A review of resident #021's electronic record by Inspector #602 indicated that on an identified date the home's physician ordered a lap belt and a tilt wheelchair be used as follows: "PASD- may have a front closing seat belt when up in wheelchair for safety. The chart review indicated that both PASDs are required due to resident #021's physical decline, high risk for falls and non-ambulatory status.

In an interview on February 16, 2017, the Director of Care (DOC) indicated that the home is currently reviewing their process specific to the use of restraints and PASDs. She advised that although resident #021 has been listed for a PASD review, the need for PASD(s) and consideration of alternatives to the PASDs currently in use has not been completed. The DOC further indicated that consideration of alternatives to the use of PASD's generally, have not been regularly completed at this time.

There was no indication that alternatives to the tilt chair or the lap belt were considered or trialed nor was there an alternatives checklist found in the electronic record or the hard copy chart. [s. 33. (4) 1.]

Issued on this 6th day of March, 2017

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

Original report signed by the inspector.