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 sions 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
Aug 24, 2016	2016_30610a_0014	021288-16	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA HEALTH SYSTEM
63 THIRD STREET WELLAND HOSPITAL SITE WELLAND ON L3B 4W6

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

NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT
155 Ontario Street St. Catharines ON L2R 5K3

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

IRENE SCHMIDT (510a), KELLY CHUCKRY (611), KERRY ABBOTT (631)

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): July 19, 20, 21, 22, 25, 26, 27, 28, 29 and August 2, 3, 4, 5, 2016.

In addition to conducting this RQI, three follow up inspections were completed and complied: log #001882-16, safe storage of drugs (r. 129(1)), log #001883-16, clear direction in care planning (s. 6(1)), and log #001884-16, skin and wound assessments (r. 50(2)(a)). As well, three CI's related to falls were inspected: log #014581-15, log #021956-15 and log #017136-16 and two complaints: log # 021320-15 related to resident rights and abuse and log #000178-16 related to an admission refusal.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Care (DOC), Acting Director of Care (ADOC), dietary manager, registered nurses (RN), Registered Dietitian (RD), registered practical nurses (RPN), personal support workers (PSW), and recreation therapy staff. In addition, inspectors observed care and service delivery to residents, and reviewed policies, procedures and clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

8 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #006	2015_247508_0010	611
O.Reg 79/10 s. 50. (2)	CO #004	2015_247508_0010	510a
LTCHA, 2007 s. 6. (1)	CO #001	2015_247508_0010	631

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

The substitute decision maker (SDM) for resident #014 reported that they had not been advised of a change in medication. Review of the clinical record revealed a physician order for the identified medication to be administered daily. The box on the order sheet to reflect that the SDM was notified, was blank. Progress notes on an identified date reported a conversation between the SDM and DOC, in which the SDM was surprised to learn the resident was on the the medication and advised they would not have given consent for the use of this medication. The DOC confirmed the SDM reported they had not been contacted about this change in treatment and also confirmed the documentation reflected the SDM had not been notified. The SDM was not given the opportunity to participate fully in the development of the plan of care. [s. 6. (5)]

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

A care plan was completed for resident #201 on a specified date. This care plan provided direction to staff, that indicated the resident required one person constant guidance and physical assistance for transfers. It also indicated that the resident required one person, total dependence, for bathing. This staff assistance was required because the resident had identified symptoms.
On an specified date, the resident #201 was sitting in a shower chair. Staff were getting clothing ready for this resident when a loud bang was heard and resident #201 was lying on the floor beside their bed. It was documented in the clinical record that the resident sustained an injury.
The resident was not provided with constant guidance when preparing this resident for their bath.
Staff and the DOC confirmed that care was not provided to the identified resident as specified in the plan. [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 residents or their substitute decision-makers are given an opportunity to participate fully in the development and implementation of the resident's plan of care and that care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of receiving Residents' Council advice related to concerns or recommendations, Resident's Council receives a response, in writing.

On a specified date, resident #043 was interviewed regarding the Residents' Council process. The resident stated that the home did not respond to the Residents' Council concerns or recommendations in writing within 10 days.
On another specified date, the administrator confirmed that there was no process in place to respond, in writing, within 10 days, to Residents' Council concerns or recommendations. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, within 10 days of receiving Residents' Council advice related to concerns or recommendations, Resident's Council receives a response, in writing, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

An interview conducted with the Registered Dietitian (RD) on an identified date, established that work hours dedicated to the Long Term Care (LTC) home as well as hours dedicated to the Niagara Health System (NHS) site were recorded and tracked in a workload report. The RD was unable to provide the workload report or a record of hours dedicated solely to the LTC home. On an identified date the Administrator provided the inspector with copies of the workload report for the RD for the three specified months. The Administrator confirmed that the hours indicated were the hours worked by the RD in the LTC home. The Administrator stated that the RD may have been on vacation and that it was common practice not to cover RD vacation.
On review of documents provided by the Administrator, the home census in one month was 107 residents and the RD was on site at the home for 41.08 hours for the month. According to the census provided, the RD was required to be on site in the home for a total of 53.5 hours for the identified month, resulting in a shortfall of 11.92 hours of clinical and nutritional care for the residents.
In the second identified month, the home census was 107 residents and the RD was on site at the home for 32.93 hours for the month. According to the census provided, the RD was required to be on site in the home for a total of 53.5 hours for the second identified month, resulting in a shortfall of 20.57 hours of clinical and nutritional care for the residents.
In the third identified month, the home census was 108 residents and the RD was on site at the home for 31.67 hours for the month. According to the census provided, the RD was required to be on site in the home for a total of 54 hours for the third identified month, resulting in a shortfall of 22.93 hours of clinical and nutritional care for the residents.
The RD was not in the home for a minimum of 30 minutes per resident, per month, during three identified months. [s. 74. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was (b) complied with.

A) The home had a policy in place entitled Falls Prevention and Management. This policy stated that "residents specifically identified at risk would have a falling star magnet placed outside of their room on the door frame" by the nursing staff.
A Fall Risk Assessment was completed for resident #036 on a specified date, indicating a moderate fall risk. The current care plan for this resident indicated, as an intervention, the resident was to be placed on the Fall Prevention Program. This intervention was initiated on an identified date. On another identified date, resident #036 did not have a falling star on the door frame of their room as identified in the home's policy.
An interview conducted with the ADOC confirmed that the home did not comply with the above noted policy.

B) The Home's Policy titled Pain Assessment and Management, (page #P-05), with date of origin July 2010, and most recently revised January 2016, directed that each resident must have a formal pain assessment done on admission, quarterly, and with significant change and that the assessment tool would be found on Point Click Care (PCC), entitled comprehensive pain assessment PN. The policy also directed that, for residents with a pain score of five to six, monthly comprehensive pain reassessments (CPA) would be completed and for pain scores of seven and above, weekly CPAs would be completed by registered staff.
Resident #039 was admitted to the home on a specified date. A CPA completed on admission reported the resident experienced no pain. A wound assessment completed on an identified date reported an alteration in skin integrity and a pain level of seven. Subsequent wound assessments completed on multiple dates in a specified month, related to the alteration in skin integrity, reported pain at seven or eight, requiring completion of weekly CPAs, as per policy. However, a CPA was not completed until a later identified date, four weeks later.
The CPA completed on the later identified date, reported the resident to have a pain level of six, requiring monthly CPAs, as per policy. The next monthly CPA was completed two months later.
The CPA completed on the identified date two months later, reported a current pain level, at the time of assessment, to be a level eight, requiring weekly CPAs, as per policy. No further CPAs had been completed, nine weeks later.
During an interview with the ADOC, the above information was reviewed and confirmed. The home's policy was not complied with. (510a)

C) The Home’s policy titled Skin and Wound Management, page #S-10, originated July 2010, and revised July 2016, directed that RN’s and RPN’s would conduct and document weekly assessments for residents with existing treatments/wound care. It was confirmed by the Administrator and ADOC that the weekly wound assessments would be completed on Point Click Care (PCC), using the wound assessment PN3 document.
i) Resident #039 had wound assessments found in PCC, that identified two specified areas of altered skin integrity. Review of the clinical records related to these areas, revealed both areas continued to be assessed; however, weekly assessments were not completed or documented in PCC for specified dates, as required by policy. This was confirmed by the Administrator and ADOC. The home’s policy was not complied with. (510a)
ii) Resident #003 had an area of altered skin integrity as confirmed by registered staff. Review of the resident’s clinical record for identified time frames, revealed the resident

had two assessments completed in PCC in a nine week period. Registered staff confirmed that assessments, for identified weeks, were not completed. The home's policy was not complied with. (510a)
iii) Resident #014 had an alteration in skin integrity, as confirmed by registered staff. Review of the resident's clinical record for an identified time frame, revealed the wound was present during the identified time frame. Weekly wound assessments were not completed in PCC, for four weeks in that time frame, as confirmed by the Administrator. The home's policy was not complied with. (510a) [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was:
(a) in compliance with and was implemented in accordance with all applicable requirements under the Act.

The home's policy titled Skin and Wound Management, (page #S-10), originated July 2010 and revised July 2016, directed that a skin assessment was to be conducted for residents after a transfer to hospital greater than 24 hours if at risk for altered skin integrity, whenever there was a significant change in the health status and when a minimum data set resident assessment inventory (MDS RAI) 2.0 assessment is reviewed.
Ontario Regulations 79/10 of the Long Term Care Homes Act, 2007, under required programs, directed that skin and wound care program must, at a minimum, provide that a resident at risk for altered skin integrity receive a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission, upon any return of the resident from hospital, and upon any return of the resident from an absence of greater than 24 hours.
On a specified date, resident #201 experienced a fall. The resident was transferred to hospital where they received treatment. The clinical record further detailed that when resident #201 returned from hospital they did not receive a skin assessment by a member of the registered nursing staff. The DOC confirmed that it was the home's expectation that a skin and wound assessment be completed for residents upon return from hospital and that the home's Skin and Wound Management Policy was not in compliance with the Long Term Care Homes Act. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home's policy's are (a) in compliance with implemented in accordance with all applicable requirements under the Act and (b) are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specified date, the following used and unlabelled items were observed on the shelves and in the cupboards:
1) south west tub room: five deodorant sticks, four combs, three hair brushes and one set of nail clippers,
2) northwest tub room: eight deodorant sticks, four hair brushes and two combs, and
3) interim long term care home (ILTC) tub room, two combs and one hair brush.
On a specified date, in the ward bathroom of an identified ward room, a coffee cup was observed, which contained an unlabelled, used toothbrush. An interview conducted with staff confirmed that an unlabelled tooth brush was left in the ward bathroom. Staff confirmed that the items were in the residents' bathroom and that personal items such as tooth brushes should be labelled and should not be left in common areas such as ward bath rooms unless labelled. [s. 229. (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 to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. s. 3. (1) (11) Every licensee of a long-term care home shall ensure the following rights 11. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

A) On an specified date and time, four PSW flow sheet binders were observed on a table in the common area of the west corridor in the Long Term Care (LTC) unit. The binders contained personal health information including resident names and details related to the residents' plan of care. One resident was observed sitting in the common area with several other persons observed to pass through the room.
B) On another specified date and time, four PSW flow sheet binders were observed on a table in the common area of the west corridor on the LTC unit. PSW staff confirmed that the flow sheet binders contained personal health information including resident names and details related to the residents' plan of care and that these flow sheet binders should be stored at the nursing station.
C) On a specified date, an identified registered staff member was administering medications during the lunch medication pass on the Interim Long Term Care Unit. The medication cart was positioned outside the dining room in the hallway on the unit. The registered staff member was in the dining room, and left the electronic Medication Administration Record (e-MAR) screen unlocked. As a result, personal health information was visible to anyone walking past the medication cart, including resident name, allergies, and specific medication from this medication pass.
Approximately fifteen (15) minutes later, the same medication cart was observed in the same location of the home. During this observation, the identified registered staff was in the dining room and the e-MAR screen was left unlocked. Several resident names and room numbers were visible. A housekeeping staff member walked past this medication cart with this information visible.
On another specified date, an identified staff member was administering medication during the breakfast medication pass on the Interim Long Term Care Unit. The medication cart was positioned outside the dining room in the hallway on the unit. The registered staff member was in the dining room, and left the e-MAR screen unlocked. As a result, personal health information was visible to anyone walking past the medication cart, including resident name, allergies, and specific medication for this medication pass. A male visitor walked past this unattended medication cart with this information visible. The identified registered staff confirmed that the e-MAR screens were to be locked. An interview with the Administrator and DOC confirmed the e-MAR screens were to be locked when unattended, to ensure personal health information is kept confidential. [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to approve the applicant's admission to the home, after taking into account the assessments and information provided by the placement coordinator.

An identified individual was a resident at the home for a specified time period. The resident was discharged on an identified date. During a portion of their stay, the identified individual had identified equipment that they used, for activities of daily living (ADL). The Administrator confirmed the equipment was accommodated in the home when the individual was a resident.
On an identified date, the home received a letter from the Community Care Access Centre (CCAC) requesting re-admission for the identified individual. A response letter from the home, rejected the application for admission, citing the Long Term Care Homes Act, Section 44(7)(a), stating the home was unable to accommodate the equipment and lacked the physical environment necessary to safely meet their care needs.
During the inspection, it was observed that an another identified resident had this equipment as well, and it was accommodated by the home. In addition, the identified equipment was observed in use, in the home, by a regular visitor to the home, during the inspection. The DOC confirmed that the identified visitor does attend the facility, using the identified equipment.
The above observations, and evidence provided by the home, confirmed the home has the physical facility necessary to meet the needs of the identified resident and admission to the home should not have been denied. [s. 44. (7)]

WN #8: 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 the resident has fallen, that that resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #003 had a Fall Risk Assessment completed on an identified date, indicating that this resident was a high risk for falls. On a specified date, the resident had a witnessed fall in their room.
The home had a policy in place entitled Falls Prevention and Management. This policy indicated that the DOC would ensure that there was a post-fall assessment of a resident who had fallen. It further indicated that the registered staff were to complete the post-fall assessment.
A post-fall assessment was not completed for resident #003 after their witnessed fall on an identified date.
An interview with staff, and a subsequent interview with the acting Director of Care (DOC,) confirmed that a post-fall assessment was not conducted using a clinically appropriate assessment instrument designed for falls, when resident #003 had a witnessed fall. [s. 49. (2)]

Issued on this 29th day of August, 2016

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

Original report signed by the inspector.