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

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Inspection 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_575214_0009	011487-17	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

CATHY FEDIASH (214), AILEEN GRABA (682), ROSEANNE WESTERN (508)

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 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, July 4, 5, 6, 7, 10, 2017

The following inspections were conducted concurrently with the RQI:

-Critical Incident System inspection 027004-16 related to falls management.
-Complaint Inspection: 024733-16 related to plan of care; Residents' Bill of Rights and falls management; 026541-16 related to prevention of abuse and neglect and whistle- blowing protection; 031205-16 related to duty to protect, plan of care, weight changes, dining and snack service, therapy services, oral care, personal items and personal aids and continence care and bowel management.
-Inquiry 000908-17 related to responsive behaviours and plan of care

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Programs Manager; Food Services Supervisor (FSS); Registered Dietitian (RD); Resident Assessment Instrument (RAI) Coordinator; dietary staff; registered nursing staff; personal support workers (PSW); President of Residents' Council; residents and families. During the course of the inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; reviewed Critical Incident System (CIS) reports; observed residents during care and dining service and observed the administration of medications.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
5 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation 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 was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with O. Reg. 79/10 section 52(1)(2) that when a resident's pain is not relieved by initial interventions the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose as well as in accordance with O. Reg. 79/10 section 50(b)(iii) that required that a resident who exhibited 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.

A) According to the home's Pain Assessment and Management Policy, the registered staff are required to conduct pain reassessments based on the resident's pain score according to a scale. The policy directs staff to do quarterly assessments for a pain score of zero to four, monthly until a lower score is achieved for a pain score between five and six, and weekly until a lower score is achieved for a pain score of seven or greater.

A review of resident #002's pain level scores in the electronic Medication Administration Record (eMAR) for a specified period of time, indicated that the resident had pain levels as identified in the home's policy that required pain reassessments to be conducted, at least weekly.

Review of the resident's clinical record indicated that a pain reassessment had not been conducted as directed in the home's policy.

It was confirmed during an interview with the DOC that the home's Pain Assessment and Management Policy had not been complied with.

B) A review of resident #010's pain level scores in the eMAR for a specified period of time, indicated that the resident had pain levels as identified in the home's policy that required pain reassessments to be conducted, at least weekly.

Review of the resident's clinical record indicated that a pain reassessment had not been conducted as directed in the home's policy.

A Comprehensive pain assessment was last completed on an identified date, although the resident had pain levels that would have directed staff to conduct assessments weekly until their pain level was zero.

It was confirmed during an interview with the DOC that the home's Pain Assessment and Management Policy had not been complied with.

C) According to the resident’s clinical record, resident #004 had an identified alteration in their skin integrity which had been initially assessed by registered staff on a specified date. Treatment orders were received and implemented the following day.

The RD assessed the resident four days after the initial assessment, and identified interventions were recommended and implemented. According to the home’s skin and wound management policy, under the roles and responsibilities section, a nutritional assessment is completed by the Dietitian for residents identified as high risk, moderate or special needs at least every three months.

Resident #004 was identified as a nutritional risk and at a level that had been identified in the home's skin and wound management policy, according to the nutritional assessment completed 20 days prior to the initial nursing assessment. A review of the resident’s clinical record indicated that this assessment had been completed by the FSS and not the RD.

It was confirmed during an interview with the RD that the nutritional assessment should have been completed by the RD initially and when the RD reassessed the resident for an alteration to their skin integrity.

It was confirmed during an interview with the DOC that the home's Skin and Wound Management Policy had not been complied with.

D) A review of the home’s policy titled, “Pain Assessment and Management policy” (Nursing manual-Welland Hospital Extended Care/ Interim Long term Care Units with a revised date of January 2016) stated the following under roles and responsibilities:

i) “Conducts pain assessment on admission, readmission and at significant changes, diagnosis of painful disease and distress related to behaviors and facial grimace".

A) A CIS report submitted by the home indicated resident #020 sustained a fall on an

identified date. The resident was transferred to hospital and diagnosed with an identified injury. A review of their clinical record indicated that they were readmitted back to the home two days later. A review of their clinical record indicated that a pain assessment had not been conducted when they were readmitted to the home.

B) A review of resident #020's clinical records revealed that resident #020 sustained a subsequent fall on an identified date, requiring transfer to hospital for assessment and treatment. Resident #020 was readmitted back to the home three days later. A review of their clinical record indicated that a pain assessment had not been conducted when they were readmitted to the home.

During an interview with the DOC, it was confirmed that pain assessments had not been completed for resident #020 when the resident was readmitted back to the home. The DOC confirmed that the pain assessment and management policy had not been complied with.

Please note: This non-compliance was issued as a result of a CIS Inspection # 027004-16, which was conducted concurrently with the RQI Inspection. (Inspector #682) [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation 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 was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with O. Reg. 79/10 section 50(2)(b)(iii), that required that a resident who exhibited 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.

According to the home's Skin and Wound Management Policy under guidelines that can be considered for care planning of wounds, a referral to a dietician was not indicated until a stage III (3) wound and above.

O. Reg. 79/10 section 50(2)(b)(iii) required that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home.

During an interview with the DOC on an identified date, it was verified that the current

Skin and Wound Management Policy with a revision date of July 2016, was the current policy implemented in the home. It was confirmed by the DOC that the home's policy was not in compliance with all applicable requirements under the Act. [s. 8. (1) (a)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place in relation to the home's Pain Management and Skin and Wound policies and is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During a tour of the home on an identified date, resident #500 was observed to be sitting in their mobility device in the lobby. An item on their mobility device was observed to have white stains and the right side of their mobility device was observed to be soiled with dried material that was approximately the size of a golf ball.

An interview with the DOC on an identified date, indicated that the staff do clean the mobility devices on the night shift and that the home does have an external company that comes bi-annually to clean the resident's mobility devices and accessories. The DOC produced flow sheets for the cleaning of the specified mobility device for two identified months in a specified year. The flow sheets identified that specific items on the mobility devices were to be cleaned weekly. A review of these flow sheets identified no documentation had been included beside the resident's room number to identify that a specified item on their mobility device had been cleaned. The DOC indicated that there were also cleaning flow sheets for this specified mobility devices and other specified mobility devices; however, these were unable to be located.

The DOC confirmed that the night staff have been unable to clean the mobility devices and specified items on the mobility device in the home for the last six weeks, unless the specified items were soiled with urine or feces, as there was an increase in resident behaviours on the night shift and staff were not able to get to the cleaning of the devices or specified items on the mobility devices.

The DOC confirmed that resident #500`s mobility device had not been kept clean. [s. 15. (2) (a)]

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, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) A complaint from resident #018's Substitute Decision Maker (SDM) was received which had indicated that the resident's specified mobility device had not been cleaned.

A review of the home's policy for cleaning of mobility equipment and confirmed by the DOC, indicated that resident mobility devices were to be cleaned monthly by PSW's on the night shift and that these actions were documented on flow sheets.

A review of the resident's clinical record revealed that the flow sheet documentation for monthly cleaning of their specified mobility device was missing.

The Administrator and the DOC confirmed that not all actions taken with respect to the cleaning of resident #018's identified mobility device, had been documented.

PLEASE NOTE: This area of non -compliance was issued as a result of Complaint inspection # 031205-16 which was conducted concurrently with the RQI.

B) A review of resident #007's clinical record indicated that on a specified date, the resident was found lying on the floor in an identified area, away from their room. Documentation indicated that the fall was unwitnessed and no injuries were sustained from the fall.

A review of the resident's fall history identified that the resident had sustained an

identified amount of falls over an identified period of time and that an identified quantity of these falls had resulted in injury.

A review of the resident's written plan of care for falls indicated that the resident had a history of falls with injury and that this was related to wandering into others rooms, self - transferring, walking unaided and an unsteady gait. The plan indicated that staff were to check the resident every hour to ensure their safety.

A review of the paper daily flow sheets for a specified period in time, where staff document the care provided to the resident, indicated that hourly checks were not documented as being completed.

An interview with the DOC confirmed that staff do check the resident hourly; however, not all actions taken with respect to checking the resident hourly to ensure their safety, had been documented. (Inspector #214) [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of pain management, including pain recognition of specific and non-specific signs of pain in accordance with O. Reg. 79/10, s. 221(1) 4 and in accordance with O. Reg. 79/10, s. 219(1), in the area of falls prevention and management in accordance with O. Reg. 79/10, s. 221(1) 1, and in accordance with O.Reg. 79/10, s.221 (3), in the area of continence care and bowel management, in relation to the following: [76(7)6]

A) An interview with the DOC on an identified date, indicated that the home used an online training program for their education and training needs. A review of the training documentation for pain management indicated that there were a total of 118 direct care staff in the home assigned to the pain annual retraining and that 52 direct care staff received the annual retraining in this area in an identified year. The DOC confirmed that 44 percent (%) of staff who provided direct care to residents, received as a condition of continuing to have contact with residents, annual retraining in the area of pain management in an identified year.

B) An interview with the DOC on an identified date, indicated that the home used an online training program for their education and training needs. A review of the training

documentation for falls prevention and management indicated that there were a total of 91 direct care staff in the home assigned to the falls prevention and management annual retraining and that 37 direct care staff received the annual retraining in this area in an identified year. The DOC confirmed that 41% of staff who provided direct care to residents, received as a condition of continuing to have contact with residents, annual retraining in the area of falls prevention and management in an identified year.

C) A review of the home's training records provided by the Director of Care on an identified date, indicated that 96 out of 112 staff had not completed training in the area of continence care and bowel management in an identified year.

The DOC confirmed that 14% of staff who provided direct care to residents, received as a condition of continuing to have contact with residents, annual retraining in the area of continence care and bowel management in an identified year. (Inspector #508).

The DOC confirmed that not all direct care staff received annual retraining in the area of pain management; falls prevention and continence care and bowel management in an identified year. [s. 76. (7) 6.]

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 all staff who provide direct care to residents receive as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of pain management, including pain recognition of specific and non-specific signs of pain in accordance with O. Reg. 79/10, s. 221(1) 4 and in accordance with O. Reg. 79/10, s. 219(1), in the area of falls prevention and management in accordance with O. Reg. 79/10, s. 221(1) 1, and in accordance with O.Reg. 79/10, s.221 (3), in the area of continence care and bowel management, in relation to the following: [76(7)6], 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 failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

A) During a tour of the home on two identified dates, two gray hair brushes and two black combs with strands of hair in them were observed in an identified location in an unlabelled purple container. The hair brushes and combs were not labelled. The DOC confirmed that personal items were to be individually labelled and that not all staff participated in the implementation of the home’s Infection prevention and control program.

B) During a tour of the home on an identified date, two unlabelled grey hairbrushes with strands of hair in them were observed in an identified location. Two unlabelled toothbrushes were observed laying uncovered on the top of the hand towel dispenser in this identified location. The DOC confirmed that personal items were to be individually labelled; toothbrushes were not to be stored on top of the hand towel dispenser, and that not all staff participated in the implementation of the home’s Infection prevention and control program.

C) On an identified date, resident #008 was observed to have an identified skin alteration to a specified area. A review of the resident's clinical record indicated that a little less than one year prior, staff had documented the skin alteration to the same specified area. Documentation the following day, indicated that the specified area of the skin alteration had demonstrated specified findings. The on call physician was notified and an identified procedure and test was ordered and implemented the same day. A review of the physician’s orders indicated that a specified treatment was ordered as a result of the specified testing results.

No further documentation was recorded in the clinical record regarding the status of the resident’s identified skin alteration for approximately 13 days. Documentation in the clinical record indicated that the resident’s physician was called and a different identified treatment was ordered. No further documentation was recorded in the clinical record

regarding the status of the resident's identified skin alteration for approximately two and a half weeks. Documentation indicated that the resident's identified skin alteration continued. The next documented entry was approximately 28 days later, when documentation indicated that the identified skin alteration continued to be present and that an identified procedure and testing were implemented.

No further documentation was recorded in the clinical record until approximately three and half weeks later which indicated that the identified alteration to the resident's skin integrity continued and that care was provided. No further documentation regarding the status of the resident's identified area of skin alteration was documented.

A review of the home's policy titled, "Nosocomial Infections" (Infection Control Manual and dated with a revised date of January 2016) indicated that all suspected infections must be documented on the line listing forms provided on the unit. An interview with the Administrator on an identified date, confirmed that it is the home's expectations that all infections are documented each shift in the resident's clinical record, until the infection resolves.

The DOC confirmed that documentation of infection's as per the home's expectations had not been completed and that not all staff participated in the implementation of the home's Infection prevention and control program. [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 all 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.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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A review of resident #014's quarterly Minimum Data Set (MDS) coding dated on an identified date, indicated under section G.-Physical functioning, that the resident was coded as being bedfast.

A review of the resident's written plan of care identified that there was no planned care for the resident's status of bedfast.

An interview with the RAI Coordinator confirmed that the resident met the identified requirements of bedfast coding and that this was observed for four out of seven days, during their observation period. The RAI Coordinator indicated that the resident had an identified change in their health over an identified period of time and spent much of their time in their bed.

The RAI Coordinator confirmed that the resident's written plan of care had not set out the planned care that included the reason(s), goals and interventions for the resident's bedfast needs and preferences.

B) A review of resident #015's quarterly MDS coding dated on an identified date, indicated under section G.-Physical functioning that the resident was coded as being bedfast.

A review of the resident's written plan of care identified that there was no planned care for the resident's bedfast status.

An interview with the RAI Coordinator confirmed that the resident met the identified requirements of bedfast coding and that this was observed for four out of seven days, during their observation period. The RAI Coordinator indicated that the resident had identified changes to their health status and over an identified period of time spent much of their time in their bed.

The RAI Coordinator confirmed that the resident's written plan of care had not set out the planned care that included the reason(s), goals and interventions for the resident's bedfast needs and preferences. [s. 6. (1) (a)]

2. The licensee 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.

A) A review of progress notes for resident #018 indicated that on an identified date, the resident's SDM had requested that the resident receive assistance with an identified Activity of Daily Living (ADL) as the resident was no longer able to do this independently.

A review of the resident's MDS assessment dated with an identified date, indicated that the resident had an identified change in their abilities and that they required total assistance with their ADL's.

A review of resident #018's written care plan for this specified ADL and dated with an identified date and in place at the time of the SDM's request, indicated that the resident was independent with the identified ADL.

An interview with the DOC confirmed that the written plan of care for resident #018 had

not set out clear directions to staff and others who provided direct care to the resident. (Inspector #682)

B) A review of resident #018's progress notes indicated that the resident's SDM requested for the resident to be assessed by a specified therapist due to an identified change in their health status. The progress notes indicated that the resident was assessed by the identified therapist on an identified date and interventions indicated having the resident participate in an identified therapy program.

A review of the care plan dated with a specified date, revealed the resident was independent with their identified mobility device and did not participate in the therapy program. Progress note on the same identified date, indicated that the resident was in a specified therapy program but refused to participate.

An interview with the DOC confirmed that the written plan of care for resident #018 had not set out clear directions to staff and others who provided direct care to the resident.

PLEASE NOTE: This area of non -compliance was issued as a result of Complaint inspection # 031205-16 which was conducted concurrently with the RQI. (Inspector #682) [s. 6. (1) (c)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) During an interview with resident #001 on a specified date, they indicated that someone had come to the home and assessed them for an identified concern to an identified area on their body. The resident indicated that the identified concern was still present and they were not sure if someone was coming back to see them.

An interview with the DOC confirmed that the resident had been seen approximately seven months prior by an identified person who was able to assess their concern. The resident was provided with an identified specialist's contact information to book an appointment regarding their concern; however, they had misplaced this information.

A review of a quarterly MDS assessment dated with a specified date, indicated that under an identified section in the MDS, that the resident was not coded as demonstrating

their identified concerns.

A review of a specified monthly assessment’s completed in Point Click Care (PCC) for two identified months, indicated that the assessment contained no documentation of the resident’s identified concern.

A review of paper assessments in the resident's clinical record used to identify if the resident's concerns were present or not, were reviewed over an identified period of approximately 11 weeks. The assessments indicated that the resident was documented as demonstrating their identified concern on 10 out of the 12 assessments.

An interview with the DOC confirmed that the specified assessments completed for resident #001, were not consistent, integrated or complemented each other.

B) A review of resident #007’s clinical record indicated that on a specified date, the resident was found lying on the floor in an identified area. Documentation indicated that the fall was unwitnessed and no injuries were sustained from the fall.

A review of an identified MDS summary assessment, completed on a specified date, indicated that the resident had sustained an identified number of falls over an identified period of time.

A review of another specified assessment completed in PCC, four days following the MDS summary assessment, indicated that the resident was assessed with an identified risk for falling; had been admitted for a period of time less than they actually had been and had identified that the resident sustained a specified number of falls which were identified as less than the MDS summary assessment and that these falls occurred over an identified period of time that was greater than the time specified in the MDS summary assessment.

An interview with the DOC confirmed that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complimented each other. [s. 6. (4) (a)]

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

A) A review of resident #002's current plan of care for an identified ADL indicated that

the resident received assistance for this ADL by one staff and required constant supervision to perform another identified related ADL due to specified reasons.

The resident's plan of care for a third identified related ADL also indicated that staff should not allow the resident to perform this ADL without assistance. During an interview with staff #200 who was caring for resident #002, the staff member indicated that staff only assist the resident with the first identified ADL when the resident requests assistance and that they do not provide constant supervision.

The resident was interviewed on a specified date and confirmed that they do not receive assistance with the first identified ADL and that they perform the second and third identified ADL's by themselves.

It was confirmed during an interview with the DOC that the care set out in the plan of care was not provided to the resident as specified in the plan.

B) A CIS report submitted by the home indicated that resident #020 sustained a fall on an identified date. The resident was transferred to hospital and diagnosed with an identified injury. Resident #020 had sustained subsequent falls after their return from hospital on 12 identified dates over a period of approximately 10 months following.

A review of the MDS coding dated with an identified date, indicated that the resident required extensive assistance of one to two staff with their activities of daily living (ADL). Three months later, their MDS coding indicated that they required total assistance with ADL's. Three months later, the MDS coding for the resident indicated that the resident was not able to and never or rarely made decisions.

A review of their plan of care, dated with a specified date, revealed that resident #020 was identified as a specified risk for falls and required the use of a specified device to perform an identified ADL. Current care plan interventions indicated that the resident was to be checked hourly to ensure their safety and required two persons to perform a specified ADL for supervision and physical assistance.

A review of the home's Fall Prevention Multidisciplinary committee minutes for an identified year, confirmed that resident #020 was discussed at three specified meeting dates, during an identified year. Identified interventions were reviewed and included in their care plan.

A review of the home's Kardex created on an identified date, indicated that the resident required two person's to perform an identified ADL for constant supervision and or physical assist. A fall logo that was observed and indicated that the resident required two persons to perform this identified ADL.

An interview with front line nursing staff #106 and #189 on a specified date indicated that the resident independently performed this identified ADL and were checked every two hours to ensure safety. During an interview with front line nursing staff #144 on an identified date, they indicated that the resident required one person physical assistance and supervision and that they do not seek another staff to assist in completing the identified ADL. The staff member and the Long Term Care (LTC Homes) Inspector reviewed the resident's Kardex and falls logo and staff #144 acknowledged that the resident required two persons to complete the identified ADL.

An interview with the DOC confirmed that the care set out in the plan of care for resident #020 was not provided as specified in their plan of care.

Please note: This non-compliance was issued as a result of CIS Inspection # 027004-16, which was conducted concurrently with the RQI Inspection. (Inspector #682)

C) A review of resident #019's clinical record indicated that the resident was assessed on admission to have a Cognitive Performance Scale (CPS) score of three (3), from a rating scale of zero (0) to six (6) with a higher score indicating more severe cognitive impairment.

A review of resident #019's written plan of care for their nutritional requirements and dated with a specified date, indicated that the menu cycle was completed by the resident's substitute decision maker (SDM) for dietary staff to follow at meal times; the resident had a specified diet type and texture; specified fluid consistency; staff were to monitor their intake daily; were not to have a specified type of fluid at meals or snacks and that the SDM requested that the resident not have a specified item at meal times.

A review of the home's complaint binder indicated that on an identified date, the SDM for resident #019 had informed the home of their concerns that the resident's dietary plan and kardex were not being followed. Documentation indicated that the home responded to the concerns and confirmed that the resident's dietary plan and kardex were correct and that actions taken included staff to review and follow the resident's dietary interventions. A response was provided to the SDM who was satisfied with the actions

taken.

An interview on an identified date with nursing staff #244, indicated that residents on modified diets were offered smaller portions of a same specified item as residents who were not receiving a modified diet.

An interview on an identified date with the Administrator and the DOC, indicated that during celebrations, all residents are offered this specified item and that recreational staff that assist in the celebrations, were not familiar with resident’s dietary care requirements.

The Administrator and DOC confirmed that the care set out in the plan of care for resident #019 regarding their dietary requirements, had not been provided to the resident as specified in their plan of care.

Please note: This non-compliance was issued as a result of Complaint Inspection’s # 024733-16 and #026541-16 that were conducted concurrently with the RQI Inspection. (Inspector #682) [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with resident #001 on an identified date, they indicated that they received a shower but preferred to have a bath. The resident indicated that they verbalized to staff that they would like to have a bath but were told that they could not have one and did not know why.

A review of the resident's written plan of care indicated that the resident was assessed to require the use of a specified device to perform an identified ADL.

An interview with front line staff #166 indicated that the bath tub on the resident's unit is unable to accommodate a resident who required a specified device to perform an identified ADL. The staff member indicated that all baths are only able to be completed on another identified unit in the home.

An interview with the DOC confirmed that the resident could be taken to the identified unit for a bath and that the resident had not been bathed by a method of their choice. (Inspector #214) [s. 33. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required.

During stage one interviews, a family member had indicated to the LTC Homes Inspector that they were not aware of a specified service provided at the home and that they wanted resident #009 to have an assessment done by this specified service.

During a review of the resident's clinical record it was verified that the resident required assistance with an identified ADL that was related to the assessment and procedures that the specified service could provide.

During an interview with the Program Manager, the Program Manager indicated that they do offer the identified service within the home on an annual basis which is communicated to residents and family through newsletters. This information is also provided in their information booklet which is provided to residents upon admission.

The Program Manager provided a copy of a newsletter with a specified date, offering these services and a copy of the information booklet; however could not provide documentation that these services were offered in an identified year.

It was confirmed during an interview with the Program Manager that residents were not offered a specified annual assessment and other preventative services, subject to payment being authorized by the resident/SDM if payment was required in 2016. [s. 34. (1) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain was not relived by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) A review of the resident's clinical record indicated that resident #002 had an identified period of pain related to specified reasons and specified area's on their body. On an identified date, the resident was ordered a specified prescription for their pain. The resident's pain level at the time of the medication administration was documented on the E-MAR using a numerical level between zero (0) to ten (10).

A quarterly comprehensive pain assessment was completed for resident #002 on an identified date; however, this pain assessment had been conducted for pain to a different specified area. Review of the resident's clinical record verified that a pain assessment using a clinically appropriate instrument had not been conducted for the specified area of pain that the specified prescription was ordered for.

It was confirmed by the DOC that when the resident's pain had not been relived by initial interventions a pain assessment was not conducted using a clinically appropriate assessment instrument specifically designed for this purpose.

B) A review of resident #003's MDS quarterly assessment dated with an identified date, indicated under a specified section that the resident was coded as having an identified level of pain, less than daily and specific sites were identified.

The corresponding Activities of Daily Living Resident Assessment Protocol (RAP) indicated that in a identified year, the resident sustained identified injuries and also had a specified procedure performed.

A review of the resident's E-MAR for an identified month and year, indicated that the resident had been prescribed identified medications which were documented as being administered. The EMAR also indicated that the resident was prescribed identified medications to be taken prn (when required) for specified reasons. A review of the EMAR indicated that the prn analgesics were administered on two identified dates; however, they were administered for reasons other than the identified sites noted in their MDS quarterly assessment.

A review of the home's policy titled, "Pain Assessment and Management" (Nursing Manual and dated with a revised date of January 2016) indicated the following:

i) Each resident must have a formal pain assessment. The assessment is done on admission, quarterly and with significant condition change. The assessment tool used is located on Point Click Care and is entitled "Comprehensive Pain Assessment PN".

A review of the resident's assessments completed in Point Click Care (PCC) over an identified period of six months, indicated that the last Comprehensive Pain Assessment completed for resident #003 was during the first month of the review period. No further comprehensive pain assessments were completed since this date, including on an identified date during the review period, when the resident's MDS quarterly coding indicated that the resident had demonstrated an identified amount of pain less than daily during the observation period.

An interview with the DOC confirmed that the resident had received their routine specified prescriptions, were coded as exhibiting an identified amount of pain less than daily during their observation period and that a comprehensive pain assessment had not been completed. The DOC confirmed that when the resident's pain was not relieved by initial interventions, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (Inspector #214) [s. 52. (2)]

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.