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

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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
Nov 15, 2016	2016_267528_0022	030404-16	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

ANSON PLACE CARE CENTRE
85 Main Street North Hagersville ON N0A 1H0

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

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): October 19, 20, 21, 24, 25, 2016

This inspections was done concurrently with Complaint Inspection Log #'s 025285-16 related to responsive behaviours, and Critical Incident System Inspection Log #'s: 016417-16 and 005066-16 related to falls management, 013990-16 related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Minimum Data Set Resident Assessment Instrument (MDS RAI) Coordinator, Quality Improvement Coordinator, Environment Services Manager (ESM), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), health care aides, activity staff, dietary staff, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

11 WN(s)
8 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. 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 staff participated in the implementation of the infection prevention and control program.

The plan of care for resident #014 identified that the resident had an infection. However, on an identified date in October 2016, there was no information posted in the resident's room to identify that additional precautions may be necessary when visiting with or caring for the resident.
The home's applicable policy "IPC D-45", last revised September 10, 2014, directed staff to place a sign on the resident's door advising all persons to go and check in at the nursing station before entering the room. Interviews with the Administrator, registered staff #104, PSW #114 confirmed that a sign should be placed on resident #014's door and was unsure as to why the sign was not present in October 2016, as required in the home's policy. (528) [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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Prevailing practices included a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. Furthermore, the document detailed guidelines for bed system evaluation and testing for potential zones of entrapment.

A. In October 2016, resident #012 was observed in bed with one bed rail raised in the guard position and the other bed rail raised in the transfer position. Review of the Initial Bed Rail Assessment completed in June 2016, indicated that the resident required bed rails to assist with positioning and was at risk of falls, but did not identify how many bed rails were to be raised and in what position. Review of the plan of care revealed they used an external device as a personal assistance services device (PASD) to promote independence in bed mobility and required one quarter bed rail. Interview with PSW #103 stated the resident required one bed rail raised to assist with transfers and bed mobility and did not consider the bed rail in the transfer position as being raised; however, confirmed there was no clear direction as to which bed rail was to be raised in

a specific position. Interview with registered staff #105 stated the resident had one bed rail raised in the guard position and the home did not consider the bed rail raised in the transfer position as being raised or in use. The registered staff did not document on their bed rail assessment how many bed rails were required and in what position the bed rails would be raised. Registered staff #105 confirmed that the home did not assess the resident for the bed rail raised in the transfer position.

B. Resident #013 was observed in bed in October 2016, with the one bed rail raised in the transfer position and the other bed rail raised in the guard position. Review of the Initial Bed Rail Assessment completed in June 2016, revealed that the resident required bed rails to assist with positioning and was at risk of falls and falling out of bed. Interview with PSW #114 stated they required one bed rail raised in the guard position, the other bed rail was always up in the transfer position and they used the bed rails for bed mobility. They also stated there was no clear direction on their Kardex as to which bed rails were to be raised and in what position. Review of the plan of care identified they required one quarter bed rail as a PASD to promote independence for bed mobility and to remain safe in bed. Interview with registered staff #105 stated the resident was to have one bed rail raised in the guard position, there was no documentation in the plan of care which directed staff which bed rail was to be raised and in what specific position and confirmed the resident was not assessed for the bed rail being used in the transfer position.

C. In October 2016, resident #014 was observed in bed with both bed rails raised in the guard position. Review of the Initial Bed Rail Assessment completed in August 2016, identified they required bed rails to assist with positioning and were at risk of falls. Interview with resident #014 stated that they had both bed rails raised when in bed in the guard position to assist in bed mobility. Review of the plan of care identified they required one quarter bed rail as a PASD to promote independence for bed mobility and was at high risk for falls. Interview with registered staff #105 stated the resident was assessed to have one bed rail raised in the guard position and confirmed they were not assessed for both bed rails to be raised in the guard position. (581) [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are not, in accordance with prevailing practices, to minimize the risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In 2016, resident #014 was admitted to the home with multiple areas of altered skin integrity. Over the course of the next eight weeks, the wound was documented opened and continued to receive ongoing treatments. In October 2016, registered staff documented a new area of skin breakdown. Review of the plan of care a week later did not include a wound assessment using Pixilar, which the home identified as the clinically appropriate assessment tool for skin breakdown. Interview with registered staff #108 confirmed that an assessment using a clinically appropriate assessment tool had not yet been completed on the new area of skin breakdown. (528) [s. 50. (2) (b) (i)]

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

In May 2016 during dinner service, registered staff #118 crushed medications into resident #40's drink for administration. The drink was placed in front of the resident at meal time but the resident did not eat or drink at the meal service and the resident's meal, including the drink, was placed in the fridge by direct care staff. Later that evening the family of resident #041's took the drink from the fridge and it was served to and ingested by resident #041. Review of investigation notes and interviews with registered staff #106 confirmed that resident #041 had ingested some of the drink with medications that were not prescribed for the resident. Interview with the Administrator confirmed that registered #118 did not ensure resident #040 ingested the medications. Although no negative outcomes resulted from the medication incident, resident #041 ingested part of a beverage containing medications that were not prescribed for the resident. (528) [s. 131. (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 that no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. In February 2016, the Minimum Data Set (MDS) Assessment for resident #012 identified that the resident was frequently incontinent of bladder. In April 2016, the MDS Assessment revealed that the resident was incontinent of bladder all or most of the time but did not identify the change in the resident's bladder assessment. Furthermore the Resident Assessment Protocol (RAPS) from April 2016, described the resident as frequently incontinent. Interview with registered staff # 105, confirmed that the MDS Assessment and RAPS from April 2016 were not consistent with and did not complement each other. (528)

B. In February 2016, the Minimum Data Set (MDS) Assessment for resident #015 identified that the resident was usually continent of bladder. In May 2016, the MDS Assessment revealed that the resident was frequently incontinent of bladder but did not identify the deterioration in the resident's bladder assessment. Interview with registered staff # 105, confirmed that the MDS Assessment from May 2016 was not consistent with the documentation of direct care staff in identifying a deterioration in resident #015's level of bladder continence. (528)

C. In 2016, resident #014 was admitted to the home with an area of skin breakdown related to pressure. An admission note by the Registered Dietitian (RD) noted that the

resident had skin breakdown and required a supplement once a day. Within two weeks, registered staff documented an worsening of the area. A referral was sent to the RD noting the resident was refusing supplementation and the RD reassessment noted the area as healed and supplementation discontinued. Interview with registered staff #107 confirmed that the RD reassessment, was not consistent with registered staff assessment, related to resident skin integrity. (528) [s. 6. (4) (a)]

2. 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.

Resident #012's plan of care was reviewed and identified that they were a two person extensive assistance pivot transfer in and out of bed and a two person extensive assistance transfer on and off the toilet. Interview with PSW #101 stated the resident was transferred in and out of bed and on and off the toilet with the sit to stand lift. Interview with PSW #116 stated the resident was transferred with the sit to stand lift, not a pivot transfer and staff were not able to use the ceiling lift as they would not be able to toilet them. Interview with registered staff #100 stated the resident was assessed by the Physiotherapist on an identified date in 2016, who documented that the PSW staff reported the resident was unable to use the sit to stand. The Physiotherapist assessment identified the resident was able to weight bear for transfers and staff were to continue to transfer the resident with a two person extensive assistance pivot transfer and if they had increased fatigue, were non weight bearing or non-compliant they were to use the ceiling lift and report any changes in transfer status to registered staff. Interview with registered staff #105 stated there was no documentation in the progress notes identifying the resident was too weak or unsteady to be transferred with two staff and a pivot transfer and confirmed that the care set out in the plan of care was not provided related to their transfers. (581) [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 the following:
i. that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other
ii. that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

In 2016, resident #015 was admitted to the home and placed in a room with resident #042. A Responsive Behaviour Risk Screening Tool completed on admission identified that resident #015 was a high risk to self and others. Multiple triggers were identified and the resident was placed into a room with resident #042 who displayed some of those triggers as responsive behaviours . Following admission, resident #015 expressed agitation and upset with resident #042. In July 2016, an altercation occurred between resident #015 and #042. Progress notes confirmed that the beds of the resident were placed in close proximity and resident #015 was able to reach resident #042 from their bed, superficially injuring resident #042. Interview with registered staff #100 confirmed that although resident #042 displayed behaviours that were a trigger for resident #015, who was identified as a high risk, they were placed in a room together. The home did therefore not prevent risk of altercation by placing resident #015 and resident #042 in the same room and within close proximity to each other. (528) [s. 54. (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 that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #7: 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. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan was implemented.

A. On an identified dat in October 2016, for approximately six hours, resident #015 was not provided with assistance to use the toilet. Review of Minimum Data Set (MDS) Assessment from August 2016, identified that the resident was frequently incontinent of bladder and occasionally incontinent of bowels and the Resident Assessment Protocol (RAPS) stated that staff were to remind and assist the resident with toileting. Review of the plan of care revealed that the resident required one person extensive assistance with toilet use, required a continence product, and directed staff to modify the environment to support continence, but did not include any directions to staff related to reminders for the resident to use the toilet or when staff were to do so. Interview with PSW #109 confirmed that the resident only sometimes asked to use the bathroom and was incontinent of bladder and bowels at times. Interview with registered staff #100 and #106 confirmed that the resident required assistance to use the toilet, was not able to consistently ask to use the bathroom, and was frequently incontinent. Furthermore, registered staff confirmed that the plan of care did not direct staff on how to manage bowel and bladder continence. (528)

B. On an identified day in October 2016, for two and a half hours, and on an identified day in October 2016, for six hours, resident #012 was not observed to be provided with any assistance with toileting or incontinent care. Review of the resident's plan of care identified that the resident was frequently incontinent of bladder, required the assistance of staff to transfer, and in order to manage incontinence directed staff to toilet the resident as per their scheduled toileting plan. Specific times were identified in the plan of care in which staff were to assist the resident to the toilet: between 0630-0700 hours, between 0845 to 0915 hours, between 1245 to 1315 hours, between 1600 to 1630, between 1830 to 1900, between 2100 to 2130 hours, between 0200 to 0230, and as needed. Interview with PSW #109 and registered staff #100 and #106 confirmed that the resident was to be toileted at specific times. During the observed times in October 2016, resident #015's plan of care to promote and manage bladder continence was not implemented. (528) [s. 51. (2) (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 that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan is implemented, to be implemented voluntarily.

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 failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's Fall Prevention Program, revised March 2014, identified that all residents would be assessed post falls to determine the extent and type of injuries and to assess contributing factors that would have caused the fall using a tool specifically designed for this purpose.
i. The Post Fall Assessment Policy, indicated the resident would be assessed after each fall using the Risk Incident (RIM) assessment in the electronic documentation system and if there was evidence of a head injury, initiate the head injury routine immediately and follow the Head Injury Routine (HIR) protocol
ii. The resident would be assessed every shift for the next 24 hours. Observe for changes in behaviour, functional and neurological changes.

iii. The risk incident documentation would include a progress note that summarizes the assessment and the care plan updated as needed.
iv. The home's policy, Head Injury Routine, revised April 30, 2015, indicated that vital signs would be checked and recorded for 72 hours on the Neurological Flow Sheet as follows: every 15 minutes for one hour, every 30 minutes for one hour, every hour for four hours and every 8 hours for seven shifts.

A. Resident #012 sustained multiple unwitnessed falls in September and October 2016. Review of the plan of care identified the following:
i. The post fall note was not completed on the evening shift after the fall on two occasions.
ii. The HIR was not initiated after one unwitnessed fall and all sections were not completed post fall for a second occasion, as per the home's policy.

B. Resident #050 sustained two unwitnessed falls in January 2016, requiring treatment for one of the incidents. Review of the plan of care identified the following:
i. The post fall assessment was was not completed after one incident, as per the home's policy.
ii. The post falls note was not completed on evening shift after the second incident.
iii. The HIR was not initiated following the second incident.

Interview with registered staff #105 confirmed that resident #012 and resident #050 were not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Resident Falls Prevention Program and Head Injury Policy. (581) [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home's policy "RCS E-115: Risk Management", dated February 2015, directed staff to document all incidents in "Risk Management", which were to be reviewed by the Director if Nursing and Personal Care within seven days. Incidents outlined in the policy included but were not limited to, altered skin integrity.

In September 2016, the family of resident #042 reported new area of altered skin integrity to registered staff. Review of progress notes identified that an investigation was completed by the evening staff and communicated to the family the following day; however, a risk management incident report was not completed. Interview with registered staff #100 confirmed that a risk management incident report should have been completed as a way of notifying the Director of Nursing and Personal Care and had not been completed, as required in the home's policy, for resident #042's new area of altered skin integrity reported by their family. (528)

B. Review of the home's policy, Bed Rails, revised July 15, 2015, identified that all residents would be assessed at the time of admission to determine if bed rail(s) were required and the need for bed rail(s) would be reassessed with any change in the resident's status or at least quarterly to reduce the risk of entrapment.

i. Resident #012's Initial Bed Rail Assessment was completed in June 2016, and indicated they required one quarter bed rail raised when in bed. Review of the plan of care identified their bed rails were not reassessed quarterly as directed by the home's policy and confirmed by registered staff #105.

ii. Resident #013's Initial Bed Rail Assessment was completed in June 2016, and identified they required one quarter bed rail raised when in bed. Review of the plan of care revealed a quarterly reassessment of their bed rails was not completed. Interview with registered staff #105 stated the registered staff were starting to assess resident's need for bed rails quarterly and confirmed it was not completed for resident #013. (581) [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, monitoring of all residents during meals.

During the course of the insepction, resident #044 was seen eating outside of the dining room with a family member, unsupervised. Review of the resident's plan of care and interview with family identified that the resident had a history of chewing and swallowing difficulties. On both days, a meal tray was dropped off to the resident and the family member. The family member was observed providing limited to extensive assistance with eating and at no time during the meal service did staff go back to monitor the resident. Interview with registered staff #100 and the Administrator confirmed that the resident was not supervised during meal service when the family was with resident #044. (528) [s. 73. (1) 4.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

In May 2016, resident #041 ingested some of a drink that contained medications for resident #040. The resident's SDM and physician was notified but registered staff #118 did not report the incident to the Director of Nursing and Personal Care. According to the home's policy "RCS F-45: Medication Incident", last revised July 2013, outlined that all medication incidents were to be immediately reported to the nurse and Director of Nursing and a Medication Incident Report must be completed immediately following the incident and forwarded to the Director of Nursing. Review of investigation notes and interview with the Administrator confirmed that a Medication Incident Report was not completed and forwarded to the Director of Nursing and Personal Care, as required in the home's policy. (528) [s. 135. (1) (b)]

Issued on this 2nd day of February, 2017

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

Original report signed by the inspector.