Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2017	2017_556168_0018	009902-17	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

LISA VINK (168), MELODY GRAY (123)

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): May 25, 26, 29, 30, 31, June 1, 2, 6, and 7, 2017.

Inspector L Bos #683 participated in this inspection.

During the course of this inspection the following was completed concurrently:
Inquiry
004412-17 - for a Critical Incident - related to plan of care

Complaints
030440-16 - related to sufficient staffing, continence care and bowel management, recreation and social programs, accommodation services - maintenance and meal services
010074-17 - related to falls prevention and management and medication management

Critical Incident Reports
001898-17 - related to falls prevention and management
033033-16 - related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Quality (QI) Coordinator, Resident Assessment Instrument (RAI) Coordinator, Environmental Services Supervisor/Nutritional Services Supervisor (ESS/NSS), Program Manager, dietary aids, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW's), family members and residents.

During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant policy and procedures, reviewed specific meeting minutes, relevant audits and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On May 25, 2017, the servery door in the Sunroom dining area was left open, with no staff in attendance or supervising and resident #040 was observed wandering in the room.
The Inspector was able to enter the servery and turn on the toasters at which time the elements in both appliances became hot.
On request PSW #107, entered the dining room and confirmed that the door was to be kept closed and locked when staff were not present to prevent the residents, including resident #040, from being in the room when it was unattended.
The PSW closed and locked the servery door, reported that the latch was not working properly and immediately reported the issue to Environmental services staff #107 who repaired the latch.

The home was not a safe and secure environment for its residents. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (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. (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 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.

Resident #023 was identified at a risk for falls according to their plan of care.
The resident had a Fall Assessment Tool completed on an identified date in 2017 and a second Fall Assessment Tool completed the following day.
A review of two assessments identified that they were not consistent with each other related to use of a device, nor for specific medication use.
Interview with the QI Coordinator confirmed that the two assessments were not consistent with each other and there was no change in the resident's use of the device or medications between the two assessment dates.

Staff did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee 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.

A. Resident #023 had more than one Substitute Decision Makers (SDM) in place who made care decisions on their behalf.
The resident had a physician's order to begin a new medication in 2017.
A review of the progress notes and the Physician's Order sheet did not identify that a SDM or the resident was notified of the new medication.
Interview with one of the resident's SDMs verified that they were not informed of all medication orders.
Interview conducted with RN #123, who processed the order identified that they could not specifically recall the physician's order in question, nor the shift, but was aware of the expectation to notify the SDM, obtain consent and document this on the Physician's Order sheet as well as in the progress notes.
Interview with the DOC verified the expectation that the resident and/or SDM be informed of the initiation of all new medication orders.
B. Resident #015 had a Substitute Decision Maker (SDM) in place who made care decisions on their behalf.
A review of the clinical record identified that they developed a new area of altered skin integrity in 2017.
The resident was assessed and treatment was initiated.
There was no documentation located in the record to indicate that the SDM was notified of the area of altered skin integrity or the initiation of a treatment.
It was noted that a member of the resident's family visited the home the following day, became aware of the issue.
The family, then contacted the resident's SDM, by phone.
The DOC confirmed that the home was not able to locate any documentation to support that the SDM was informed of the new area of altered skin integrity or treatment; however, when investigated it was identified that registered staff indicated that they did attempt to contact the resident's SDM when the area was identified, without success, and that family visited the following day.
The home completed a Client Service Report (CSR) related to this concern which indicated that the SDM was not informed of the area of altered skin integrity.

The resident or the SDM, was not provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. 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. Resident #030 had fall in 2017.
The plan of care identified an intervention to "initiate med review if any of the following conditions arise" including "falls" due to the resident's diagnosis.
A review of the clinical record did not include a medication review during the time the resident sustained the fall.
The plan of care was reviewed by RN #125, who verified the intervention was required as part of the plan of care; however, identified that the medication review was not completed post fall.
B. Resident #022 sustained a fall in 2017, while attempting to reach for their call bell as identified in the clinical record.
A review of the plan of care indicated that the resident's call bell was to be within their reach.
RPN #108 and the DOC verified that the resident fell when trying to reach for their call bell which was not in reach as per the plan of care.

Care was not provided as specified in the plans of care. [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 that the resident, the SDM, if any, and the designate of the resident / SDM are provided the opportunity to participate fully in the development and implementation of the plan of care and 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 #3: 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. Ont. Reg 79/10 section 48(1)4 identified that a pain management program shall be in place to identify pain in residents and manage pain.

The home provided procedure Pain Management, RCS G-60 revised date July 15, 2013, which identified that "upon initiation of a new pain medication or an adjustment to dosage and/or frequency, a Pain Flow Sheet shall be initiated" and that staff were to "evaluate the effectiveness of the medication on the Pain Flow Sheet as well as in the residents electronic progress notes".

i. Resident #023 had an order to begin a new medication for the management of pain in 2017.
A review of the clinical record did not include the presence of a Pain Flow Sheet.
A review of the progress notes beginning at the time that the medication was ordered and the 12 days proceeding included only notes that the resident had no complaints and noted other symptoms observed; however, not specifically related to the effectiveness of the medication.
A review of the electronic Medication Administration Record (eMAR) included the evaluation of pain, using a pain scale; however, did not include other information included on the Pain Flow Sheet, specifically, a description of the pain, sedation scale and any side effects to the medication.
Interview with the DOC identified the need to complete the Pain Flow Sheet with the initiation of, or a change in dosage in pain medications.
The DOC was not aware if a Pain Flow Sheet for the resident was completed or not;

however, identified that RN #120 would be aware if this document was completed.
RN #120 verified that a Pain Flow Sheet was not completed for the resident when the new medication was initiated.
ii. The plan of care for resident #011 identified the potential for pain related to a diagnosis.
A review of the clinical record identified that the resident routinely received a narcotic analgesic for pain management.
In 2017, the resident had an increase in their analgesic according to the physician's orders and eMAR for the identified month.
A review of the clinical record did not include a Pain Flow Sheet completed at the time that the increased dosage of analgesic was initiated.
Interview with RPN #101 could not recall a Pain Flow Sheet for the resident at the time that the analgesic was increased and identified that it would had been initiated by the staff member who processed the physician's order.
RN #120, who processed the physician's order for the change in analgesic, could not recall implementing or completing a Pain Flow Sheet for the resident for the identified time period.

B. Ont. Reg 79/10 section 68(2)e identified that the licensee shall ensure that the nutrition care and hydration programs included a weight monitoring system to measure and record with respect to each resident.

The home's policy and procedure Height and Weight Monitoring - FNSCN076 identified that "Each resident will be weighed monthly between the 1st and the 7th day of the month and the weight is recorded in the weight/vitals tab. Weights are to be completed by the PSW on or before the 7th day of the month. For any weight change of 5% or more from the previous month, the Unit Supervisor will verify by re-weighing the resident. Re-weighs must be completed within 24 hours and entered into PCC. IMPORTANT: In the event a re-weigh is entered into PCC, you must decide which weight is the correct one and strike out the incorrect one".

i. According to the weights and vital signs tab in Point Click Care (PCC) resident #011 had a weight obtained in March 2017, another weight was half a kilogram (kg) less in April 2017 and a third weight in May 2017 which was almost four and a half kg less than the March 2017, weight recording.
The recorded weights generated a "weight warning" in PCC, which indicated that the May weight was a change of 7 percent (%) compared to the April weight.
There was no documented re-weight recorded in the weights and vital signs section of

PCC until May 21, 2017.
This was confirmed by the RD.

The home did not follow it's Height and Weigh policy and procedure. [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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee to failed to ensure that each bedroom, occupied by more than one resident, had sufficient privacy curtains to provide privacy.

On May 25 and 29, 2017, it was observed that resident's #010, #012, #013 and #017, were in shared rooms which had privacy curtains that did not provide sufficient privacy, at the head of their beds.
Ceiling lift tracking prevented the curtains, in place, from providing complete privacy.
The privacy curtains did not extend to the walls at the head of the beds, which allowed for a gap of approximately 40 centimeters (cm), 40 cm, 50 cm and 45 cm, respectively, from the tracking to the walls.
Interview with resident #013 identified awareness of the privacy issue, indicated that this was a concern for them as they had no filter from their roommates light and communicated knowledge of the plans in place to provide new curtains.
Interview with the Administrator verified the concerns with some privacy curtains related to the installation of ceiling lifts, which were most recently completed at the end of 2016.

The Administrator identified their actions to modify as many curtains as possible, prior to this inspection, to provide privacy.
New window coverings and privacy curtains were ordered for all resident rooms earlier in May 2017 and it was confirmed that each room would be equipped with curtains which would provide full privacy in approximately six to eight weeks according to the Administrator.

Each residents bedroom did not have sufficient curtains to provide privacy. [s. 13.]

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 each bedroom, occupied by more than one resident, has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #5: 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 and that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment and other safety issues related to the use of bed rails including height and latch reliability.

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.

Resident #013 was observed with a specific bed rail at the foot of their bed, a transfer rail at the head of the bed on one side and a quarter rail in the guard position on the other side of bed.
On observation it was identified that the specific rail was raised higher off of the bed frame, than the rails provided by the home, and had a larger opening between the rail top and mattress.
A review of the plan of care included the use of the transfer and guard rails only.
Interview with the resident identified that the home did not provide the specific rail for use; however, it was unclear when the rail was applied to the bed.
Interview with RPN #110, the Administrator and DOC identified that they were not aware of the use of the domestic rail until it was identified by the Inspector.
A review of the Facility Entrapment Inspection Sheets from January 2016, identified that the resident's bed was tested for quarter rails and passed zones one through seven with a mattress keeper in place; however, there was no mention of the specific rail.
According to the DOC, registered nursing staff completed a Personal Safety Devices audit on all residents in the home in early May 2017 and the use of the specific rail was not identified as part of this audit.

There was no assessment in place for the resident with the domestic rail as part of their bed system to minimize risk to the resident. [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 none, in accordance with prevailing practices, to minimize risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment and other safety issues related to the use of bed rails including height and latch reliability, to be implemented voluntarily.

WN #6: 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.

On May 25, 29 and 31, 2017, the underside of a tub chair was identified with a buildup of debris that could be scraped/rubbed off.
Interview with the DOC on May 30, 2017, indicated that there was now specific staff who were responsible for bathing and also cleaning the tubs and chairs.
A review of the document "Cleaning of commode chairs and shower chairs between resident uses," identified that staff were to "rinse the commode chair with commode seat, above surface and underneath with water, spray these surfaces with Virox/Accel TB and

allow to sit for 10 minutes, and return in 10 minutes, scrub these surfaces with the scrub brush provided and rinse with clear water." It was confirmed that this process would be followed for the cleaning of the tub chair as well.
On May 31, 2017, PSW #116 observed the tub chair on request and confirmed that it was not clean.

The home did not ensure that all equipment was kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A. On May 25, 2017, the following was observed:
i. The Main dining room had a hole approximately one centimeter (cm) deep and eight cm in diameter on the entrance door; two water stains approximately 30 cm in size were noted on the ceiling near a light fixture to the right of the rooms entrance, another water stain was noted also on the ceiling as well as peeling paint.
ii. In the Sunroom dining area there was a yellow, opaque area of discoloration approximately one meter (m) in diameter on the inside of the light fixture in front of the fireplace.
iii. Resident #041's bed was identified to have one quarter bed rail which was loose and moved laterally when shaken, which was confirmed with program staff #115, who verbalized that they would immediately document the concern in the home's maintenance request system. Interview with maintenance staff identified that they would repair the rail immediately.
iv. The over bed light of residents #042 and #015 did not turn on when the string was pulled which was confirmed with PSW #114 who verbalized that they would document the issues in the home's maintenance request system.
v. A brown water stained area approximately one and a half meters in size was noted on the ceiling above the entrance to residents #043 and #044's room as well as approximately 20 cm of drywall tape hanging down from the area.
vi. A brown water stain approximately half a meter in size was noted on the ceiling at entrance of the room for resident #041.
Interview with maintenance staff and the ESM confirmed the observations of the Inspector.
B. On May 25, 2017, a tub was observed to have two irregular shaped chips on the inside bottom of the tub surface.
These areas measured approximately three and a half cm by two cm at the largest part and approximately three cm by two cm at the largest part.

Interview with the Administrator identified that they would explore options to address the concern, such as an overlay.

The home did not ensure that all equipment was maintained in good state of repair. [s. 15. (2) (c)]

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 and that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

On May 25, 2017, it was identified that a resident-staff communication system was not available in the Sun room dining area, which was used by residents.
The ESM and the Administrator confirmed that a resident-staff communication and response system was not available in the area.
Interview with the Administrator on June 19, 2017, identified the home's plans to have the resident-staff communication and response system installed in the Sun room dining area by the middle of July 2017. [s. 17. (1) (e)]

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-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A. Resident #021 was observed on May 25 and 30, 2017, with a device in place while up in their chair.
Interview with the resident identified that it was their preference to wear the device and that they were able to apply and remove it independently.
A review of the plan of care identified the device was a personal assistance services device (PASD) as the resident was able to remove it. On May 30, 2017, RPN #111, observed the application of the device on request.
The RPN verified that the device was not applied according to manufacture's instructions and adjusted it.
Interview with the resident verified that at times the device was loose, in their opinion.
B. Resident #020 was observed on May 25 and 30, 2017, with a device in place while up in their chair.
A review of the plan of care identified the device was a personal assistance services device (PASD) as the resident was able to remove it and could ask for it to be removed.
On May 30, 2017, RPN #111, observed the application of the device on request.
The RPN verified that the device was not applied according to manufacture's instructions and adjusted it.

The devices were not applied in accordance with manufacturer's instructions. [s. 23.]

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 use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #9: 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.

The records of residents #011, #015, and #046 were reviewed including Point of Care (POC) documentation related to turning and repositioning for May 2017.
The plans of care indicated that each resident was to be turned and/or repositioned every two hours.
The POC documentation reviewed did not indicate that the residents were consistently turned and or repositioned every two hours according to the schedule.
The records suggested that some documentation was recorded late, others documented before the two hour time period or that the intervention was not documented at all.
The DOC confirmed that the interventions provided were not documented as required in the records. [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 #10: 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 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.

Resident #012 was observed to have an area of altered skin integrity, which was open to the air on one date and covered with a dressing five days later.
A review of the clinical record confirmed the area was assessed in "Pixalere" on a specific date, at which time it was noted to be "scabbed".
A treatment was applied to the area for one week in 2017.
A review of the clinical record did not include an assessment of the resident by the RD.
Interview with the RD confirmed that if they received a referral for the area they would have completed and documented an assessment.
Interview with RPN #117 who was the wound care lead confirmed that a referral had not been submitted to the RD due to the reason for altered skin integrity.
A review of the skin and wound management program identified that when a resident had an area of altered skin integrity (which included skin tears, pressure ulcers, and any other wounds or breakdown) the RD would be notified.

The resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a registered dietitian. [s. 50. (2) (b) (iii)]

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 has altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who was a member of the staff of the home, to be implemented voluntarily.

WN #11: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning of residents who require assistance.

On May 30, 2017, during the evening meal, resident #011, who had a plan of care related to eating, called for help and staff member #124 responded by feeding them one spoonful of their meal while standing behind them.
The resident was observed to swallow the food fed to them from behind without difficulty.

The staff verbalized that they had tried to assist the resident when they called out for help, confirmed that they did not use proper feeding techniques during their efforts and were aware that their actions were not acceptable to feed the resident from behind.

Proper techniques were not used to assist the resident with eating. [s. 73. (1) 10.]

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 proper techniques are used to assist the residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Family of resident #024 indicated that they had expressed verbal concerns to the home regarding care and services provided.
Interview with the Administrator confirmed that the home had met with the family member frequently to address concerns in 2016; however, not all issues were able to be resolved within 24 hours.
The home was not able to produce a documented record related to any concerns expressed by the complainant in 2016.

The home was not able to provide a record which included, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant. [s. 101. (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 documented record is kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions

Resident #019 was observed on May 25 and 26, 2017, with a device in place while up in their chair.
A review of the plan of care identified the device was a restraint.
On May 26, 2017, RPN #101, observed the application of the device on request.
The RPN verified that the device was not applied correctly and proceeded to adjust the it.
Interview with the DOC on May 30, 2017, verified the application of the device according to manufacturer's instructions and staff direction.

The device was not applied in accordance with manufacturers' instructions. [s. 110. (1) 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 the physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #14: 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 that every medication incident which involved a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and 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.

A review of the Medication Incident Reports for January, February and March 2017, identified a medication incident for resident #020 which was not documented as required nor were all required individuals notified.
A review of the medication incident report noted that on on identified date in 2017, the resident was given an additional dose of a medication.
Interview with the DOC clarified that the internal investigation identified that on the identified day, at 1600 hours, the resident was not given a medication as ordered; however received both the 1600 hour and 2000 hour dosage at 2000 hours.
A review of the clinical record did not include any progress notes recorded for the shift when the error occurred.
The first entry in the progress notes, following the incident, was for the day shift the following day.
A review of the incident report did not include an assessment of the resident, immediate actions to maintain their health nor documentation to support notification of the resident, the SDM, or the physician, as confirmed during an interview with the DOC.
A late entry regarding this incident was included in the clinical record on May 31, 2017, which confirmed that the resident was monitored and displayed no ill effects from the incident. [s. 135. (1)]

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

Issued on this 20th day of June, 2017

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

Original report signed by the inspector.