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
Sep 13, 14, 2016	2016_243634_0015	025350-16	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 WONHAM STREET SOUTH INGERSOLL ON N5C 3P6

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

ADAM CANN (634), INA REYNOLDS (524), JANETM EVANS (659), SHERRI GROULX (519)

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): August 22, 23, 24, 25, 26, 29, 30, 31, September 1, and 2, 2016.

The following intakes were completed within this Resident Quality Inspection:

Critical Incident log # 009478-15, CIS # 2628-000020-15, related to alleged staff to resident abuse.

Critical Incident log # 011993-15, CIS # 2628-000021-15, related to alleged staff to resident abuse.
Critical Incident log # 013952-15, CIS # 2628-000023-15, related to a missing resident.
Critical Incident log # 024809-15, CIS # 2628-000025-15, related to alleged staff to resident abuse.
Critical Incident log # 026300-15, CIS # 2628-000027-15, related to alleged staff to resident abuse.
Critical Incident log # 027080-15, CIS # 2628-000026-15, related to a resident fall.
Critical Incident log # 031133-15, CIS # 2628-000029-15, and CIS # 2628-000030-15 related to resident to resident abuse.
Critical Incident log # 009731-16, CIS # 2628-000003-16, related to water temperature.
Critical Incident log # 011220-16, CIS # 2628-000004-16, related to alleged staff to resident abuse.
Critical Incident log # 011347-16, CIS # 2628-000005-16, related to missing money.
Critical Incident log # 022053-16, CIS # 2628-000009-16, related to a resident fall.
Complaint log # 020172-16, IL-45480-LO, related to Registered Nurse coverage.
Complaint log # 022880-16, IL-45425-LO, related to a restraint.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, the Food Services Supervisor/Environmental Services Supervisor, the Registered Dietician, two Registered Nurses, five Registered Practical Nurses, one Dietary Aide, one laundry staff, twelve Personal Support Workers, the Family Council and Residents' Council Representative, and over 40 residents.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, meal and snack services, medication administration and storage areas, and required Ministry of Health and Long Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

s. 6. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has 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.

An interview was conducted with a family member on August 23, 2016. The family member stated staff were not always available to provide toileting assistance.

Review of the progress notes and plan of care for the resident under the bowel focus directed staff to toilet the resident at a specified time to promote regular bowel movements and to reduce agitation.

A Personal Support Worker (PSW) shared that this intervention was not documented on the Kardex to set out clear direction to staff. Staff interview with a Registered Nurse indicated it was the home's expectation that direction to the Personal Support Workers was provided in the Kardex in Point of Care as they did not have access to this information elsewhere in the plan of care.

A Registered Nurse and the Resident Assessment Instrument Coordinator further said that the plan of care was not consistent as the bowel intervention provided for the PSWs was not linked to the Kardex. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Documentation revealed that the resident had multiple diagnoses. The plan of care stated that the resident was to have a restraint in place.

According to a quarterly Restraint/Personal Assistance Services Device (PASD) assessment, dated December 29, 2015, it listed that the resident was currently using a restraint.

According to the documentation in the progress notes, the Occupational Therapist (OT) recommended the restraint be removed which the Power of Attorney agreed to have removed.

Documentation in the Restraint/PASD assessments, dated on March 30, 2016 and June 16, 2016, it stated that the resident was to use a device but did not list the restraint.

Review of the resident’s physician orders revealed that the physician had ordered the use of the restraint to continue on a quarterly medication review.

Review of the resident’s care plan stated the resident was to have the restraint on at all times.

Upon interview with a Registered Nurse (RN), it was stated that the resident did not wear the restraint any longer. The RN stated that a current physician order that indicated the restraint was discontinued was necessary. The RN reviewed the care plan with the inspector and stated it was not up to date. [s. 6. (10) (b)] (519)

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 plan of care of each resident sets out clear directions to staff and others who provide direct care to residents, and to ensure that residents plan of care are reviewed and revised every six months and at an other time when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all alarms for doors leading to the outside were connected to a back-up power supply or if the home did not have a generator, did staff monitor the exit doors in accordance with the procedures set out in the emergency plans.

According to the Critical Incident System (CIS) report an incident occurred when the magnetic door locks were not functioning.

Upon interview with the Environmental Services Supervisor, it was stated that when the magnetic door locks were not functioning staff were positioned at the doors on each wing, the door to the basement, the north corridor, and the front door. The maintenance task list for a specified day indicated that the magnetic door locks were not functioning in the afternoon.

The home's policy titled, "Code Grey - Infrastructure Loss/Failure", XVII-D-10.80, dated May 2016, stated under "Mag Lock Failure" 1. Announce Code Grey 2. Assign team members to exits, stairwells, and emergency doors 3. Attempt to reset Mag Locks 4. Call for service 5. Complete resident census to ensure all residents are accounted for.

The licensee failed to ensure that staff monitored the exit doors in accordance with the procedures set out in the emergency plans, when the magnetic door locks were not functioning. [s. 9. (1) 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 the alarms leading to the outside are connected to a back-up power supply or that staff monitor the doors according to the procedures set out in the home's emergency plans, to be implemented voluntarily.

WN #3: 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 had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

(A) During Stage One of the Resident Quality Inspection (RQI) it was observed on August 22, 2016 at and August 23, 2016, that a resident had bilateral half bed rails raised.

During an interview with Personal Support Worker, it was stated that the resident used the bed rails to assist him/her when the resident was transferred out of bed.

During an interview with the resident, the resident stated that he/she used the bed rails to assist him/her when the resident moved in bed.

During an interview with Resident Assessment Instrument (RAI), it was stated that the resident used the bed rails for bed mobility but that the home had not completed the assessments to determine the safety of the bed rails for the resident.

During observation of the resident, it was observed that he was lying in his bed with one half bed rail and one transfer bed rail in the raised position. (519)

(B) During Stage One of the Resident Quality Inspection (RQI) it was observed that a resident had bilateral half bed rails raised.

During an interview with a Personal Support Worker (PSW), it was stated that the resident used the bed rails to assist resident when repositioning in bed and turning.

During an interview with the resident, the resident stated that he/she used the bed rails to assist with moving in bed.

During an interview with the Resident Assessment Instrument (RAI) Coordinator, it was stated that the resident used the bed rails for bed mobility but that the home had not completed the assessments to determine the safety of the bed rails for the resident. (634)

(C) During Stage One of the Resident Quality Inspection (RQI) it was observed on that a resident had bilateral half bed rails raised.

During an interview with a Personal Support Worker (PSW), it was stated that the resident used the bed rails to assist him/her when repositioning and turning while in bed.

During an interview with Resident Assessment Instrument (RAI) Coordinator, it was stated that the resident used the bed rails for bed mobility but that the home had not completed the assessments to determine the safety of the bed rails for the resident. (634)

The home's policy titled, "Bed Rails", number VII-E-10.20, last revised June 2016, stated, "bed rails may be used to manage the potential risk of injury in bed when the action or mobility of the resident is involuntary or unpredictable; or the use of bed rail (s) enables the resident greater mobility, repositioning, or freedom of movement while in bed. The safety of residents positioned in beds with raised side rails and pads will be assessed and monitored. The RN/RPN will 1. assess resident's need for the use of bed rail and entrapment risk. 2. document on the resident's care plan the resident's need for bed rails, including the number of rails to be raised and the decision to use, remove, or change bed rails. If a bed rail of any size is used, the Restraints/PASD assessment must be completed to identify the device as either a restraint or a PASD".

The licensee failed to ensure that multiple residents had been assessed and their bed system evaluated for the use of bed rails. [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 has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

During Stage One of the Resident Quality Inspection (RQI) it was observed, that a resident had bilateral half bed rails raised.

During an interview with Personal Support Worker (PSW) #, it was stated that the resident used the bed rails to assist him/her when they were transferred out of bed.

During an interview with the resident, they stated that he/she used the bed rails to assist him/her when they moved in bed.

During an interview with Resident Assessment Instrument (RAI) Coordinator it was stated that the resident used the bed rails for bed mobility but that the home had not obtained the consents for the bed rails to be used as a Personal Assistance Services Device (PASD).

During observation of the resident, it was observed that the resident was lying in their bed with one half bed rail and one transfer bed rail in the raised position.

During an interview with Registered Practical Nurse (RPN), it was stated that the consent for two half bed rails to be used as a PASD for the resident had not been obtained, and the bed rails were not included in the care plan.

The home's policy titled, "Bed Rails", number VII-E-10.20, last revised June 2016, stated "bed rails may be used to manage the potential risk of injury in bed when the action or mobility of the resident is involuntary or unpredictable; or the use of bed rail (s) enables the resident greater mobility, repositioning, or freedom of movement while in bed. The safety of residents positioned in beds with raised side rails and pads will be assessed and monitored. The RN/RPN will 1. assess resident's need for the use of bed rail and entrapment risk. 2. document on the resident's care plan the resident's need for bed rails, including the number of rails to be raised and the decision to use, remove, or change bed rails. If a bed rail of any size is used, the Restraints/PASD assessment must be

completed to identify the device as either a restraint or a PASD".

The licensee failed to ensure that the use of two half bed rails for the resident as a PASD, had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 33. (4) 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 the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living is included in residents plan of care only if the use of the PASD has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give consent, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance.

On August 22, 2016, the call bell system in the lounges and specific resident rooms was not functioning properly. The inspectors observed the call bells system were not functioning in the resident lounges and in resident rooms. Interviews with Personal Support Workers (PSW) confirmed that they were not receiving notification on their pager that a call bell had been activated.

Documentation from Work Orders dated July 24 to August 24,2016, showed evidence of malfunctioning of nurse call bell system. Review of the work orders indicated that the Food Service Supervisor/Environmental Service Manage had documented in the maintenance care program about the malfunctioning call system.

From an interview with Food Service Supervisor/Environmental Service Manager it was stated that the expectation was when the home's maintenance staff were unable to successfully complete repairs and work orders, that they should notify her and that she could call a third party for repairs. She confirmed that she had not been notified of the malfunctioning of the nurse call system and that work orders related to the malfunctioning call bell system had not been completed.

The home's policy and procedure in place for testing and confirming the proper operation of the nurse call system : Policy # V-C-30.30 titled Nurse Call System dated as current revision January 2015. The policy stated that the "nurse call system operation will be tested and confirmed not more than monthly to ensure proper operation for the safety of all residents, staff and family".

In an interview with the Food Service Supervisor/Environmental Service Manager (FSS/ESM), Dietary and Environmental Partner (DEP) , it was confirmed that documentation of the testing of the nurse call system could not be produced. The Licensee failed to show evidence of compliance with the procedure with respect to documenting and recording all devices, locations, tests and staff undertaking the tests of the nurse call system. [s. 90. (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 procedures were implemented to ensure that the electrical and non-electrical equipment is kept in good repair and maintained, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

A Critical Incident Systems (CIS) report was submitted to the Ministry Of Health and Long-Term Care which stated that a resident had fallen.

The resident had been assessed by physiotherapy who indicated that resident was at risk to fall. The resident's care plan did not include a focus or interventions related to falls prevention and management.

Record review was completed of the home's Falls Preventions Policy # VII-G30.00. The policy said that "upon completion of a detailed fall risk assessment, update care plan with associated risk level and interventions".

Interview was conducted with the Director of Care (DOC) who said that when a falls risk assessment was completed the expectation was that the plan of care gets updated with risk level and related interventions. They confirmed that the plan of care did not identify resident's risk level or any interventions related to falls. [s. 26. (3) 10.]

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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an

assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) According to documentation, it was noted that a resident was frequently incontinent of bladder and occasionally incontinent of bowel.

During an interview with Personal Support Worker (PSW), it was stated that the resident wore briefs for urinary incontinence but that the resident was toileted about every two hours by the direct care staff.

Upon review of the resident's chart, there was no evidence of an admission continence assessment or a three day voiding diary. A completed bowel and bladder continence assessment could not be located on Point Click Care (PCC) under the assessment tab since the resident's admission to the home.

During an interview with the RAI/MDS coordinator, it was stated that a bowel and bladder continence assessment had not been completed for the resident since their admission to the home, as it could not be located in PCC or in the resident's hard copy chart. (519)

B) According to documentation, it was noted that a resident was occasionally incontinent of bladder and continent of bowel. A clinical record review indicated the resident had a decline in bladder and bowel function and was frequently incontinent of urine and incontinent of bowel. There was no documented evidence of a continence assessment for this resident.

Interview with the Registered Practical Nurse after review of PointClickCare stated that the resident did not have a continence assessment completed and one should have been done. (524)

C) According to documentation, it was noted that a resident was occasionally incontinent of bladder.

During an interview with Personal Support Worker (PSW), it was stated that the resident wore briefs for urinary incontinence but that the resident was toileted about every two hours by the direct care staff.

Upon review of the resident's chart, evidence of a completed bowel and bladder continence assessment could not be located on Point Click Care (PCC) under the assessment tab.

During an interview with the RAI/MDS Coordinator, it was stated that a bowel and bladder continence assessment had not been completed for resident since their admission to the home. (634)

The home's policy titled, "Continence Program - Guidelines for Care", dated as revised January 2015, stated "Registered Staff will upon admission, annually, and when there is a significant change in condition that impacts bowel and bladder functioning: obtain information about the resident's bowel and bladder routine, identify contributing factors to incontinence, reference bladder and bowel assessment, and implement bowel protocol as per physicians order".

The licensee failed to ensure that multiple residents who were incontinent, received a Bowel and Bladder Continence assessment that included the identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required. [s. 51. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee had failed to inform the Director no later than one business day after the occurrence of the incident of: 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A) A resident experienced a fall, in which they sustained an injury.

Review of the Long-Term Care Homes Critical Incident System used to report incidents to the Director, failed to identify a report related to the identified incident. The Director of Care said that she was unable to find a report related to this critical incident and there should have been a report completed. (524)

B) Documentation revealed that a resident had a fall in which they sustained an injury.

During an interview with the Director of Care # (DOC) on August 30, 2016 it was stated that she could not find a Critical Incident System report (CIS) that was submitted to the Ministry of Health and Long-Term Care about this incident. She looked in her records and on the LTCH.Net site and could not verify that a CIS had been submitted. (519) [s. 107. (3) 4.]

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 14th day of September, 2016

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

Original report signed by the inspector.