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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Feb 24, 2015	2014_269597_0009	S-000538-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court 523 Algoma Street North THUNDER BAY ON P7A 5C2

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

PIONEER RIDGE
750 TUNGSTEN STREET THUNDER BAY ON P7B 6R1

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

BEVERLEY GELLERT (597), DEBBIE WARPULA (577), MARGOT BURNS-PROUTY (106)

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): December 9 - 19, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental and Laundry Services Supervisor, RAI Coordinator

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

As evidenced by:

The current care plan for Resident #022 was reviewed on December 16, 2014, by Inspector #597. Under the Nursing Focus of ADL Assistance, the interventions listed included that the resident uses wheelchair with a restraining device, for all locomotion on and off unit. The Nursing Focus of Physical Restraints, identified the same restraining device for Resident #022. The Nursing Focus of Injury from Falls, lists the intervention of a different type of restraining device for use while up in wheelchair.

Resident #022 was observed by the inspector on two days during the inspection, to have only one type of restraining device in place.

#S-101 was interviewed by Inspector #597 on December 18, 2014. Staff reported that Resident #022 uses only one type of restraining device. A second type of restraining device was in place for this resident but it was discontinued months ago.

#S-102 was interviewed by Inspector #597 on December 18, 2014. Staff reported that Resident #022 requires only one type of restraining device while they are up in their chair.

The physician's order for Resident #022, lists only one type of restraining device for

resident safety and the consent signed by POA lists this same device as the restraint currently in use for this resident. [s. 6. (1) (c)]

2. The licensee has failed to 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).

As evidenced by:

Resident #043 had an unwitnessed fall in late 2014. A record review of Resident #043's progress note on that date, indicated that the resident was found by a staff member, on the floor lying beside the bed.

On December 15, 2014, Inspector #577 reviewed Resident #043's care plan related to falls. The care plan indicated that resident is a high risk for falls. There are many fall prevention interventions in place for this resident. It was identified by the inspector that, not all fall interventions had been initiated by the home on the date of this resident's fall. [s. 6. (7)]

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

As evidenced by:

Resident #043 has a history of cognitive impairment with responsive behaviours displayed toward residents and staff. On December 18, 2014, Inspector #577 reviewed Resident #043's medication orders.

On December 18, 2014, the inspector reviewed Resident #043's care plan related to responsive behaviours. The care plan included interventions to administer medication when behavioural interventions are ineffective for responsive behaviour.

Inspector #577 reviewed Resident #043's progress notes relating to behaviour and medication for three months in 2014 and it was found that this resident did not receive the prescribed medications as ordered on several occasions when they were required. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care provided to

the resident as specified in the plan.

As evidenced by.

The physician's orders in the Health Care Record of Resident #022 were reviewed by Inspector #597. A skin/wound daily treatment was ordered for this resident.

The Treatment Administration Records (TAR), were reviewed for staff signature indicating that the treatment had been administered. Inspector #597 found that staff had signed for this daily treatment on only four occasions in a three month period.

The current Care Plan for Resident #022 was reviewed by Inspector #597. The Care Plan indicated that this resident does have an impaired skin condition and lists the interventions that are in place, including the application of the skin/wound treatment

#S-102, was interviewed by Inspector #597 and reported that RPNs are responsible to apply the skin treatment. [s. 6. (7)]

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

As evidenced by:

Inspector #577 reviewed Resident #045's care plan related to falls. The care plan indicated that resident is at risk for falls due to cognitive impairment. Fall risk strategies are in place and care plan indicates that a specific device be used when the resident is in bed.

On December 18, 2014, the inspector observed this resident lying in their bed, with one full rail raised up. The specific device was observed in the resident's room but not in use, to minimize potential injury from falls.[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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and the licensee shall ensure that the care set out in the plan of care, specifically in regards to Residents #022, #043, #045, is provided as specified in the plan, 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 has failed 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 practises and, if there are none, in accordance with prevailing practises, to minimize risk to the resident.

As evidenced by:

During the inspection, Resident #001 was interviewed by Inspector #106 while in bed, the inspector noted that 2 side rails were in the up position. The Health Care Record for resident #001 was reviewed and it indicated that the resident used the side rails for bed mobility.

On December 17, 2014, Inspector #106 asked #S-104 how residents are assessed for the use of bed rails. They indicated that residents will tell staff what rails they want up or families will request for rails to be up. Staff will also determine the need for bed rails if they feel that the residents require them for bed mobility or safety, this may be documented at admission or in the nursing notes.

On December 17, 2014, Inspector #597 interviewed the DOC regarding how residents are assessed for use of bed rails and they reported that bed rails are used if there is a resident/family preference and/or if nursing staff assess the need for them for safety or bed mobility. The home does not assess residents for bed rail use in accordance with prevailing practises to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practises, and if there are none, in accordance with prevailing practises to minimize risk to the resident.

As evidenced by:

On December 17, 2014, Inspector #597 interviewed the DOC regarding how residents are assessed for use of bed rails and the DOC reported that bed rails are used if there is a resident/family preference and/or if nursing staff assess the need for them for safety or bed mobility. The home does not assess residents for bed rail use in accordance with prevailing practises to minimize risk to the resident.

#S-105 was interviewed by Inspector #597 on December 18, 2014. They reported that they were in the process of assessing bed systems in the home, all beds are fairly new and that the home is aware that new beds purchased must meet legislative standards. They confirmed that not all beds have been assessed. The home's plan is to check all beds as per Health Canada's Recommendations on a monthly basis.

#S-106 was interviewed by Inspector #597 on December 18, 2014, regarding bed rail and bed system assessments. They stated that they have established a preventative maintenance binder and the bed systems are being checked according to Health Canada Recommendations. The department has checked approximately 70% of beds in the home to date. The DOC is working with the vendor of the beds, to ensure that legislative

standards are met. A policy for the bed system assessment has not yet been developed. [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 practises and, if there are none, in accordance with prevailing practises, to minimize risk to the resident, to be implemented voluntarily.

WN #3: 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. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).

5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

As evidenced by:

Inspector #597 reviewed the Treatment Administration Record (TAR) for Resident #025 for the month of December 2014. There were no initials to indicate that the resident was assessed for the effectiveness of and continued need for their restraining device every 8 hours and as necessary on 15 shifts.

Inspector #597 reviewed the Treatment Administration Record (TAR)for Resident #025 for the month of December 2014. There were no initials to indicate that the resident was assessed for the effectiveness of and continued need for their restraining device every 8 hours and as necessary on 12 shifts.

On December 18, 2015, #S-107 was interviewed by Inspector #597. They reported that they are aware of the restraint interventions that are in place for this resident and that registered staff are responsible to reassess resident's condition and the effectiveness of the continued need for the restraint every 8 hours and as needed and sign on the Treatment Administration Record.

The Resident Care Flow Sheet for the month of December 2014, revealed that this resident was in the home on all days for all shifts. [s. 110. (2) 6.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

As evidenced by:

The current Care Plan for Resident #021 was reviewed by Inspector #597 on December 18, 2014. The care plan includes a Nursing Focus of Physical Restraints related to the use of a restraining device with the interventions of registered nursing staff and/or other staff members, as designated by registered staff must monitor Resident #021 every hour while restrained. RPN to assess resident's condition and the effectiveness of and the need for the restraint every 8 hours and as necessary, and document on Treatment Administration Record. PSW to complete and sign restraint use record every shift, and RPN and/or PSW must release resident from their physical restraint and reposition them every 2 hours and as required.

The Treatment Administration Record for Resident #021 was reviewed by Inspector #597. It was noted that there were no signatures by the RPN to indicate that the Resident was assessed as indicated in the plan of care regarding the restraining device on 8 shifts.

The Restraint Record for Resident #021 was reviewed by Inspector #597 on December 18, 2014. There was no documentation completed by the PSW to indicate that the resident was assessed as indicated in the plan of care regarding the restraining device. There were no signatures or application codes documented on the Restraint Record to indicate that the resident was monitored on 12 hourly checks.

There were also no signatures or evaluation codes documented on 2 evening shifts in this same time period.

The Resident Care Flow Sheets for Resident #021 were reviewed by Inspector #597 and were completed for all dates and shifts over one month indicating that the resident was present in the home. [s. 110. (7)]

3. The licensee has failed to ensure that the documentation included the person who applied the device and the time of application.

As evidenced by:

The Restraint Record for Resident #022 was reviewed by Inspector #597 for a month in 2014. The current Care Plan indicated that registered nursing staff or other staff members as designated by registered staff, must monitor resident every hour while restrained. The Restraint Record is to be signed and completed every shift. The Care Plan indicated that the RPN and/or PSW must release resident from their physical restraint and reposition them every 2 hours and as required.

Review of the Restraint Record for Resident #022 revealed that there was no application codes, evaluations codes or staff initials documented to indicate that the resident was monitored on 22 hourly.

Inspector #597 reviewed the Resident Care Flow Sheet for Resident #022 for a month in 2014. The Flow Sheet indicated that the resident was present in the home and up in

their wheelchair on the above mentioned dates. [s. 110. (7) 5.]

4. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

As evidenced by:

The current Care Plan for Resident #022, stated that RPNs are to reassess the resident's condition, the effectiveness of and continued need for the restraint every 8 hours and as needed, documenting their actions on the Treatment Administration Record.

Inspector #597 reviewed the Treatment Administration Record for Resident #022 for a month in 2014. There was a requirement for the RPN to sign every 8 hours. For a two week period in 2014, only 73% of required documentation was completed.

Inspector #597 reviewed the Resident Care Flow Sheet for Resident #022 for a month in 2014. The Flow Sheet indicated that the resident was present in the home on the above mentioned dates.[s. 110. (7) 6.]

5. The licensee has failed to ensure that the documentation included every release of the device and repositioning

As evidenced by:

Inspector #597 reviewed the Restraint Record for Resident #022 for the month of December 2014. The current Care Plan indicated that registered nursing staff or other staff members as designated by registered staff, must monitor resident every hour while restrained. The Care Plan also indicated that the RPN and / or PSW must release resident from their physical restraint and reposition them every 2 hours and as required.

Review of the Restraint Record for Resident #022 revealed that there were no release and repositioning codes and staff initials documented on 22 hourly checks.

Inspector #597 reviewed the Resident Care Flow Sheet for Resident #022 for a month in 2014. The Flow Sheet indicated that the resident was present in the home and up in their wheelchair on the above mentioned dates.

Inspector #597 interviewed #S-101 on Dec 18, 2014 and they confirmed that PSW responsibilities regarding seat belt include application, removal, repositioning and residents have to be checked every hour and staff need to sign on the Restraint Record. [s. 110. (7) 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 following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances and ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The person who applied the device and the time of application,all assessment, reassessment and monitoring, including the resident's response, very release of the device and all repositioning and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care for Residents #021, #022, #025 and all other residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

As evidenced by:

During the inspection, Inspector #106 observed resident #004 asleep in their wheel chair while in the lounge for 50 minutes. Resident #004 was not tilted back in their wheel chair and was positioned in an up right sitting position.

Inspector #106 interviewed #S-108 who stated that when resident is asleep in the wheel chair in the morning, staff will tilt them back in their wheel chair instead of putting them back to bed because the resident's family will be in to visit them. During the inspection, a family member for Resident #004 indicated that they were concerned that the resident is sometimes left asleep in their wheel chair instead of assisted back to bed where they could sleep comfortably. [s. 3. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 (b) is

complied with. O. Reg. 79/10, s. 8 (1).

As evidenced by:

On December 15, 2014, Inspector #577 reviewed the Health Care Record for Resident #041 and noted significant weight loss over a one month period.

Inspector #577 spoke with #S-109, who reported that staff have been inaccurately recording weights by not subtracting the weight of the wheelchair for past 6 months, #S-109 confirmed the current, accurate weight of this resident.

It was further reported by #S-110, that Resident #041 has not had a significant weight loss, and staff had been inaccurately recording weights by not subtracting wheelchair weight. #S-110 reported that December's documented weight is accurate.

Inspector #577 reviewed home's policy on "Weight and Height Monitoring", revision date February 2014. The policy indicated that resident weight is done both on admission and monthly thereafter. Weights do not include adaptive equipment (wheelchair weights must be subtracted from weight totals). Should a resident experience significant weight change, nursing staff will retake the residents weight prior to entering it into the electronic medical record for verification.

The staff failed to subtract the weight of the wheelchair, recorded inaccurate weights and did not follow the home's policy for weight monitoring. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that 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 (b) is complied with. O. Reg. 79/10, s. 8 (1).

As evidenced by:

On December 15, 2014, Inspector #577 found on review of the Health Care Record that Resident #043 had a documented significant weight loss over a one month period in 2014.

Inspector #577 reviewed the home's policy on Weight and Height Monitoring, on December 17, 2014. The policy reads, "A weight monitoring system will measure and record every resident's weight both on admission and monthly thereafter. Weight changes will be assessed using a multi-disciplinary approach. Should a resident experience significant weight change, nursing staff will retake the resident's weight prior to entering it into the electronic medical record for verification. The Registered Nurse will inform the Registered Dietitian, and if needed, the Nurse Practitioner and/or physician of any weight changes. The Registered Dietitian will follow up on all weight variance reports in the electronic medical record".

On December 17, 2014, Inspector #577 spoke with #S-109, who reported that when there is a weight loss change, staff are supposed to send the Registered Dietitian a referral. #S-109 further reported that they did not receive a referral from nursing regarding Resident #043's weight loss.

The Registered Nurse will inform the Registered Dietitian, and if needed, the Nurse Practitioner and/or physician of any weight changes. The Registered Dietitian will follow up on all weight variance reports in the electronic medical record. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when 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).

As evidenced by:

Resident #043 had an unwitnessed fall. Inspector #577 reviewed the record of Resident #043's progress note on the day of the fall that indicated, that the resident was found by staff on the floor lying beside the bed.

The inspector reviewed Resident #043's care plan related to falls. The care plan indicated that the resident is a high risk for falls.

Upon review of the Health Care Record, Inspector #577 was unable to find a completed post fall assessment for this resident.

On December 18, 2014, the inspector spoke with #S-111 RAI Coordinator, who reported that the clinical assessment tool to be used by staff post falls is the Fall Risk Screening Tool.

#S-111 confirmed that staff did not complete this post fall assessment tool for this resident's fall. [s. 49. (2)]

2. The licensee has failed to 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.

As evidenced by:

Resident #045 had an unwitnessed fall with an injury. Inspector #577 reviewed the home's Fall's Prevention and Management Program, revision date January 2014. The policy indicated that "when a resident has fallen, the resident is assessed and a post fall assessment is completed".

On review of the Health Care Record, Inspector #577 was unable to find a completed post fall assessment for this resident.

On December 18, 2014, the inspector spoke with #S-111 RAI Coordinator, who reported that the clinical assessment tool to be used by staff post falls is the Fall Risk Screening Tool.

#S-111 confirmed that staff did not complete this post fall assessment tool for Resident #045's. [s. 49. (2)]

WN #7: 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 has 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 is specifically designed for skin and wound assessment.

As evidenced by:

Inspector #597 interviewed #S-110 regarding the recent injury to Resident #021. #S-110 stated that the RPN staff would chart the wound assessment in progress notes. The home has a Wound/Skin Assessment Tool that can be used for injuries as well as pressure ulcers etc. #S-110 confirmed that this assessment tool had not been used to assess the injury to Resident #021.

The progress notes for this resident were reviewed by Inspector #597. A skin and wound assessment for Resident #021 was not found. [s. 50. (2) (b) (i)]

WN #8: 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 has failed to ensure that 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.

As evidenced by:

The Health Care Record for Resident #001 was reviewed by inspector #106, specifically in regards to continence. It was found that the resident required a specific intervention to manage their continence care needs. The inspector asked #S-112 and #S-113 to provide the completed continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

#S-113 provided the inspector with a "City of Thunder Bay, Homes For The Aged Continent Assessment". The assessment was created in 2008, revised in 2009, and it indicated that the resident required this intervention regularly. A new assessment had not been completed when the resident's health status and continence care needs changed. [s. 51. (2) (a)]

2. The licensee has failed to ensure that 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.

As evidenced by:

Inspector #106 reviewed the Health Care Record for resident #003, specifically in regards to continence, it was found that the resident was incontinent. During the inspection, the inspector noted that the resident smelled of urine. The inspector asked three staff members to provide a continence assessment that was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence and they were unable to do so. [s. 51. (2) (a)]

3. The licensee has failed to 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).

As evidenced by:

On December 15, 2014, Inspector #577 reviewed Resident #043's care plan specifically related to urinary incontinence. The care plan indicated that the resident required a specific intervention to manage their continence care needs.

On December 17, 2014, the inspector spoke with #S-114 who reported that a medical history report from Resident #043's admission to an acute care hospital in 2011 indicated that this intervention had been initiated at that time.

Inspector #577 interviewed #S-115, who reported they think that this intervention is in place because the resident is incontinent.

Inspector #577 interviewed #S-107 who reported that they think the intervention is treating this resident's medical condition.

Upon record review of the resident's chart, Inspector #577 did not find a medical history indicating reason for this intervention, or a Continence Assessment form .

Inspector #577 spoke with DOC on December 17, 2014 who reported that a "Continence Assessment" form is completed on admission and considered their clinical tool for assessment of incontinence. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

As evidenced by:

On December 17, 2014, Inspector #577 spoke with #F-200, a member of the Family Council, who reported they have been part of the Family Council for 5 years. They reported that Executive Director and Director of Nursing are always at the Family Council meetings. Inspector reviewed meeting minutes documented from Family Council meeting held on June 23, 2014, where the resident concerns documented were for improved continence management and residents sleeping in chairs at meal times. #F-200 reported that the home does not respond to the Family Council in writing related to concerns. [s. 60. (2)]

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they inform the Director immediately, in as much detail as is possible in the circumstances, of each of the following incidents in the home:
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

As evidenced by:

Critical Incident System (CIS) report was, submitted to the Ministry of Health and Long-Term Care, on July 2, 2014, indicates that an enteric outbreak was declared by the Health Unit on June 30, 2014. On December 17, 2014, the DOC confirmed that July 2, 2014, was the date the home first reported the outbreak to the Director. [s. 107. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs;

As evidenced by:

Resident #043 has a history of cognitive impairment with responsive behaviours displayed towards residents and staff. On December 18, 2014, Inspector #577 reviewed this resident's medication orders prescribed for responsive behaviors.

On December 18, 2014, Inspector #577 reviewed Resident #043's care plan related to responsive behaviours. Care plan includes interventions to aid with behaviour, such as administration of medication when behavioural interventions are ineffective for responsive behaviour.

Inspector #577 reviewed this resident's progress notes relating to behaviour and medication for three months in 2014. There was documentation of one occasion in which medication was administered to this resident for resonsive behaviors yet there was no documentation of the resident's response to medication given. [s. 134. (a)]

Issued on this 26th day of February, 2015

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

Original report signed by the inspector.