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

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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
Jan 8, 2016	2015_248214_0028	034562-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 Overlea Blvd. TORONTO ON M4H 1P4

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

R. H. LAWSON EVENTIDE HOME
5050 JEPSON STREET NIAGARA FALLS ON L2E 1K5

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

CATHY FEDIASH (214), GILLIAN TRACEY (130)

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 14, 15 16, 17 and 18, 2015.

Please note: The following inspections were conducted simultaneously with this RQI: Complaint inspection 023771-15 related to falls, nutritional care and weight loss and Critical Incident System inspection 026533-15 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Food Services Supervisor (FSS), Director of Activities, registered staff, Personal Support Workers (PSW), President of Residents' Council, family representative of the Family Council, resident's and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes and internal investigation notes; reviewed policies and procedures; observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:
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
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

According to the plan of care, resident #101 had a Safety Device Assessment/Re-assessment completed on an identified date in 2015. The assessment indicated that the resident currently used two bed rails, front fastening seat belt, chair alarm and a bed alarm as safety devices and also indicated that the resident is to use one bed rail. The assessment also indicated that the resident can undo the device and also indicated that the resident was unable to undo/get out of the device. The assessment further indicated that the resident may or may not be able to undo/get out of r/t cognition. The assessment was reviewed by the DOC, who confirmed the information gathered contained conflicting information and did not provided clear directions to staff providing care. [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

According to the Safety Device Assessment /Re-assessment completed on an identified date in 2015, for resident #102, the resident required two bedrails when in bed for safety. The Resident Assessment Protocol (RAP) completed on the same date also indicated the resident required two rails raised while in bed; however; the written plan of care indicated the resident required one rail raised when in bed for safety. The actual needs of the resident required that two siderails be raised with the bed lowered to the floor, for safety. The DOC confirmed the written plan of care was not based on the assessed needs of the resident. [s. 6. (2)]

3. 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 change or care set out in the plan was no longer necessary.

A) During an interview with resident #105, they indicated that at times they have to wait to receive assistance with toileting. A review of the resident's current plan of care indicated that staff are to take the resident to the bathroom as they return from the dining room, remain in the room and remove from the toilet when they are finished. On an identified date in 2015, resident #105 was observed to be assisted by staff #052 from the dining room to their room. The staff member assisted the resident to their chair and provided the call bell. The resident was not observed to be toileted. An interview with staff #052 indicated that the resident will ask staff for assistance to the toilet and will use their call bell for assistance to come off the toilet and that staff do not remain in the room with the resident. A review of the resident's current plan of care was conducted with staff #052 and the DOC. The DOC confirmed that the resident's plan of care was not reviewed and revised when the resident's needs changed. (Inspector #214)

B) Resident #204 sustained a fall on an identified date in 2015, which resulted in injury. The resident required surgical interventions and returned to the home from hospital several days later. According to the readmission progress notes, the resident returned from hospital with identified special treatments in place. The written plan of care had not been updated to include these special treatments, the potential risks to the resident, including potential for infections, nor the interventions required to monitor them.

This information was confirmed by the DOC.

This non-compliance was identified as a result of the following inspection: #023771-15, which was conducted simultaneously with the RQI. (Inspector #130) [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set's out clear directions to staff and others who provide direct care to the resident; to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences and to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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.

i) The home's Weight Change Management policy (7.07.11) dated November 2015, indicated that "any resident identified by Nursing as having experienced a significant unplanned weight change will be investigated and assessed by the Registered Dietitian". "Referrals are made to the RD for residents with a significant weight loss or inappropriate

weight gain. Nursing re-weighs the residents with questionable weights to confirm the weight".

A) According to the weight summary record for an identified period of time in 2015, resident #100 sustained a weight gain of 5 percent (%) over a period of one month. From this identified period of time, the residents weight recorded 30 days and 60 days later indicated a weight loss of 7.8% over this one month period in time.

The DOC and the FSS confirmed the resident was not reweighed when weight variances were identified and that referrals were not sent to the RD for follow-up. (Inspector #130)

B) During completion of census records during stage one of the RQI, it was indicated that resident #106 had sustained a weight loss. A review of the resident's weight history in Point Click Care (PCC) for an identified period of time in 2015, indicated that the resident had a weight loss of 14.7% over a one month period. No documentation was included that a re-weigh for this resident had occurred.

The DOC and the FSS confirmed the resident was not reweighed when weight variances were identified and that referrals were not sent to the RD for follow-up. (Inspector #214)

C) According to the Weights and Vitals summary report for an identified period in 2014, resident #204 sustained a weight loss of 15% over a 17 day period. A review of the next recorded weight seven days later and a recorded weight three months from this date indicated that the resident had a weight gain of 9.6% over this three month period in time. A review of the resident's weights for a one month period of time in 2015 indicated that the resident sustained a weight loss of 22%.

The DOC confirmed that the resident was not re-weighed when weight variances were identified. The FSS confirmed referrals were not made by nursing when weight variances were identified.

The home's Weight Change Management policy (7.07.11) was not complied with.

This non-compliance was identified as a result of the following inspection: #023771-15, which was conducted simultaneously with the RQI. (Inspector #130)

ii) The home's Falls – Prevention and Management policy (9.11.14) dated March 2014, indicated that if staff were not present during the fall: "monitor the resident's status for the

next 24 hours even if the resident shows no signs of distress or has sustained only minor injuries, monitor vital signs as per head injury routine if you know or suspect the resident has hit their head; notify the doctor if you note any change from the baseline". The policy also indicated: "Documentation after a fall: Complete a detailed resident incident report (and Unusual Occurrence Report if applicable). This report isn't considered part of the patient's record. A copy will go to the facility's Administrator, who will evaluate care given in the home and propose new safety policies as appropriate. The incident report should note: where and when the fall occurred, how the patient was found and in what position; the events preceding the fall, the names of witnesses, the patient's reaction to the fall; a detailed description of resident's condition based on assessment findings; vital signs; the interventions taken and the names of staff members who helped care for the resident after the fall; the doctor's name and the date and time that they were notified (include a copy of the doctor's report); whether the patient was sent for diagnostic tests or transferred to hospital; notification of the resident's POA/SDM (substitute decision maker), date and time and by whom; include all of this information in the patient's chart also".

On an identified date in 2015, resident #204 sustained an unwitnessed fall from bed, with no apparent injury. Documentation in the clinical record did not include a detailed description of the resident's condition based on assessment findings, vital signs, notification to the doctor or the POA.

On another identified date in 2015, resident #204 sustained a fall from their wheelchair, witnessed by a co-resident. Documentation in the clinical record did not include the assessment of vital signs and notification to the doctor.

On another identified date in 2015, resident #204 sustained an unwitnessed fall and was found on the floor. The documentation in the clinical record did not include where the fall occurred, how the patient was found and in what position; the events preceding the fall, the names of witnesses, the resident's reaction to the fall; a detailed description of the resident's condition based on assessment findings; the interventions taken and the names of staff members who helped care for the resident after the fall; the doctor's name and the date and time that they were notified. The clinical record indicated that vital signs obtained post fall indicated an elevated change from the resident's baseline. According to the clinical record, the resident was put back to bed after the fall, vitals were not reassessed and the physician was not made aware. The following day, diagnostic testing confirmed an identified injury.

The DOC confirmed the Falls – Prevention and Management policy (9.11.14) was not complied with.

This non-compliance was identified as a result of the following inspection: #023771-15, which was conducted simultaneously with the RQI. (Inspector #130)

iii) The home's Falls – Prevention and Management policy (9.11.14) dated March 2014, indicated that when managing falls: "assess the resident's limb strength and motion. Don't perform any ROM exercises if you suspect a fracture or if the patient complains of any odd sensations or limited movement. If you suspect any disorder, don't move the resident - call ambulance for transfer to ACU (acute care unit) for assessment.

According to the clinical record resident #204 sustained an unwitnessed fall on an identified date in 2015. The resident was assessed to have no injuries, toileted and returned to bed.

The following day the resident's lower extremities were assessed by both the registered nurse and the registered practical nurse and it was indicated in the documentation that there were no apparent deformities, but slight swelling noted to an identified area in the lower extremity and that the doctor to assess in the afternoon. Progress notes documented later the same day indicated that ROM(range of motion) to the lower extremities was done and no pain noted. When resident stood up to be transferred to their mobility device, they had painful facial expression when their identified lower extremity touched the floor.

The DOC confirmed that the ROM should not have been performed on the resident again following the assessment completed on the identified date in 2015, and that 911 was not called as directed in the policy, when an identified injury was suspected.

The DOC confirmed the home's policy was not complied with.

This non-compliance was identified as a result of the following inspection: #023771-15, which was conducted simultaneously with the RQI. (Inspector #130) [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 #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of the home's policy titled, Abuse (3.05.05 with a reviewed date of March 28, 2012) indicated the following:

i) Under Reporting Requirements: Staff and Volunteers who witness abuse or suspect the abuse of a Resident or who receive complaints of abuse should report the matter immediately to the Administrator (or designate).

A review of a Critical Incident Submission (CIS) that was completed by the home indicated that on an identified date in 2015, resident #105 was inappropriately touched in a non-sexual manner by a staff member to two identified areas. An interview with the DOC confirmed that this incident which did not result in injury was witnessed by another staff member who did not report the matter immediately to the Administrator or designate. The DOC confirmed that the home first became aware of the incident on the following morning when the resident reported the incident to another staff member who informed the DOC. The DOC confirmed that home had not complied with their written policy to promote zero tolerance of abuse and neglect of residents.

This non-compliance was identified as a result of the following inspection: #026533-15, which was conducted simultaneously with the RQI. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: 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 following requirements were 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.

During a tour of the home on an identified date in 2015, resident #300 was observed to be sitting in their wheelchair with a safety device applied unsafely. A review of the manufacturer's directions for this physical device indicated to secure the device across the patient's hips firmly so you can fit only two fingers between the device and the patient's body. An interview with staff #058 confirmed that the resident was unable to unfasten the device and that the device was not applied according to the manufacturer's 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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

During a tour of the home on an identified date in 2015, the following was observed:

A) On the first floor in the North shower room:

- An unlabelled black hair comb was observed to be sitting on a counter. The comb was observed to have white debris noted in the teeth of the comb.
-Two unlabelled roll on deodorants with their caps unsealed were also observed in the shower room.

B) On the second floor in the South shower room:

- An unlabelled black hair comb with hair in the teeth of the comb was observed on the counter.
- Unlabelled toe nail clippers were observed sitting on the top of a plastic cart. The toe nail clippers were observed to have areas of rust on them.

C) On the third floor in the North shower room:

-An unlabelled black comb was observed on the sink ledge and contained hair in the comb
-Unlabelled nail clippers were observed sitting on the back of the toilet in the shower room.

An interview with the DOC confirmed that the above items were to be labelled with the resident's name, kept clean and stored in the resident's room and that nail clippers were to be kept in the nail clipper caddy in the shower rooms. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that restraint by a physical device was included in the plan of care for resident #101 and #102.

A) Resident #101 was observed on an identified date in 2015, with a safety device in place. The written plan of care did not identify the use of this safety device. The resident was unable to unfasten the device at the request of Inspector #130. This information was confirmed by the resident's Substitute Decision Maker (SDM) and staff #061 and #087.

B) The Safety Device Assessment /Re-assessment completed on an identified date in 2015, for resident #102 indicated the resident had a safety device in place which they were unable to unfasten. The resident was observed by Inspector #130 on an identified date in 2015. The DOC confirmed that the resident could not unfasten the safety device and that it was considered a restraint.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The DOC confirmed that the home was currently working on the falls prevention and management program; however; the program was not fully developed and implemented at the time of this RQI. [s. 48. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutrition care and hydration programs include,(ii) body mass index and height upon admission and annually thereafter.

During stage one of the Resident Quality Inspection (RQI), staff interviews conducted indicated that not all resident's height's had been obtained on an annual basis. A review of resident #100 indicated that their last documented height was on a identified date in February 2012. Resident #104's last documented height was on a identified date in February 2014. Resident #106's last documented height was on a identified date in November 2014 and resident # 301's last documented height was on a identified date in February 2009.

An interview with the FSS confirmed that the documented heights listed in PCC were the most current heights and that they had not been obtained on an annual basis. [s. 68. (2) (e) (ii)]

Issued on this 21st day of January, 2016

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

Original report signed by the inspector.