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
Feb 6, 2017	2016_353589_0019	031361-16	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

JOANNE ZAHUR (589), ANGIE KING (644), JULIENNE NGONLOGA (502)

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): November 24, 25, 28, 29, 30, December 1, 2, 5, 7, 8, 9, 12, 13, 14, 15, 19, 20 and 21, 2016.

The following critical incident reports intakes were concurrently inspected with the resident quality inspection: #030977-16 related to abuse, #021846-16, #032998-15 and #007336-15 related to falls prevention and #002496-14 related to plans of care and skin and wound.

The following complaints intakes were concurrently inspected with the resident quality inspection: #004582-15 related to nursing and personal support services in the home, #015161-15 related to plan of care, #032595-15 related to posting of inappropriate resident photos and #017509-15 related to operational concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Support Services (DSS), Registered Dietitian (RD), Assistant Environmental Service Manager (A-ESM), Environmental Service Manager (ESM), Recreation Director (RCD), Activity Director (AD), Wellness Director (WD), Physiotherapist (PT), Medical Director (MD), Scheduling Clerk/Reception (SCR), Registered Practical Nurse (RPN), Registered Nurse (RN), Personal Support Worker(s) (PSWs), Dietary Aides (DA), Housekeeping Aide (HA), Residents, Substitute Decision Makers (SDM's), and Presidents of Residents' Council and Family Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
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.
- **12 WN(s)**
- **5 VPC(s)**
- **4 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 failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

Resident #009 triggered for an inspection in stage one of the resident quality inspection (RQI).

Record review of resident #009's progress notes revealed that he/she had a hospital leave for an identified period of time for an underlying health condition.

Observations and record review conducted by the inspector revealed that resident #009 was re-admitted to the home from a hospital leave requiring isolation precautions for an identified period of time.

Further review of resident #009's written plan of care failed to reveal he/she was required to be on Droplet precautions for five days.

Interviews with staff #110, staff #120 and staff #125 confirmed that resident #009's written plan of care was not revised on his/her re-admission from the hospital leave.to include his/her current diagnosis and the need for isolation precautions. [s. 6. (1)]

2. 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.

Resident #005 triggered for an inspection in stage one of the RQI.

Observations by the inspector during a meal service revealed resident #005 was eating a meal which consisted of an alternate texture and that he/she had only eaten 25 per cent of the meal served.

Review of the most recent Resident Assessment Instrument – Minimum Data Set (RAI-MDS) revealed resident #005 had not been assessed for any eating difficulties Review of the most recent written plan of care revealed resident #005’s correct diet texture and required fluid consistency.

Interviews with staff#100 and staff #102 stated that resident had been served alternate texture food since May 2016, related to an underlying health condition.

In an interview, staff #103 stated that an alternate textured diet had been ordered to temporarily address resident #005's underlying health condition. Staff #103 confirmed that the care set out in the plan of care had not been provided to resident #005 as per the plan of care. [s. 6. (7)]

3. A critical incident system (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which resident #003 had experienced a fall that resulted in a transfer to hospital.

The CIS report revealed resident #003 sustained two falls on an identified day in July 2016, one in the morning and the second one in the afternoon. On either incident resident #003 was not offered a mobility aid. Further review of the CIS report revealed that the second fall resulted in a transfer to hospital and a subsequent diagnosis of an injury.

The registered nurses association of ontario (RNAO) 2005, nursing best practice guideline-prevention of and fall injuries in the older adult defines a fall as, "an event that results in a person coming to rest inadvertently on the ground or floor or other lower level".

The resident assessment instrument-minimum data set (RAI-MDS) 2.0 considers a fall as:
-when a resident lost balance and would have fallen if staff did not intervene,

-if the fall resulted in an injury,
-if a resident is found on the floor and staff cannot definitively rule out a fall, it should be considered a fall, and
-when the distance to the next lower surface is not a factor. If a resident rolls onto floor from a mattress placed on the floor, it is still a fall.

Review of resident #003's written plan of care revealed that staff #119 had implemented the use of a loaner mobility aid. This mobility aid was to be used as an intervention to reduce the risk of falls when the resident was experiencing with mobility.

Review of resident #003's health record revealed that resident #003 had multiple fall incidents between a two month period. Seven of the incidents had been documented as falls, the remaining 15 incidents had been documented as near misses, a general note or as a behaviour note. These included:

Further review of resident #003 progress notes revealed the following:
- staff #119 documented ongoing monitoring of the effectiveness of the use of the mobility aid in reducing falls.
- staff #126 documented resident #003 had requested the mobility aid as he/she had sustained four falls on the same day. Staff responded by encouraging resident #003 to take his/her time, and keep his/her current mobility aid close during ambulation and did not provide the loaner mobility aid as requested.
- staff #131 documented that resident #003 had sustained another fall and staff continued to provide encouragement to ambulate with his/her current mobility aid.
- resident #003 sustained a fall and stated, he/she could not stand anymore.
- later on the on the same day, resident #003 had a second fall as a result of losing control of his/her mobility aid.

On three identified dates a review of resident #003's progress notes failed to reveal that the loaner mobility aid had not been offered to ensure the resident's safety.

In interviews, staff #119, staff #126 and #131 stated the loaner mobility aid had not been provided to resident #003 as specified in the plan of care when he/she had been experiencing difficulty with mobility using his/her current mobility aid.

In an interview, staff #125 confirmed that staff had not provided care as set out in the plan of care to resident #003. As a result, resident #003 continued to experience falls and sustained an injury. [s. 6. (7)]

4. The MOHLTC Action-Line received a complaint related to safety of the residents in the home. The complainant stated that resident #026 was wandering and once walked into a co-resident's room and exhibited a responsive behaviour.

A multidisciplinary meeting was held to address resident #026's family member's concerns related to safety as the family was very fearful that the resident would continue to exhibit responsive behaviours within the unit. It is documented that at the end of the meeting, all parties agreed for each resident to be allocated a caddy that would contain their labelled personal items and stored in a secured room. Staff #125 or staff #128 would contact family to advise when the plan indicated above had been fully implemented

Review of the progress notes revealed that resident #026's family member followed up on their concern related to resident #026's safety and asked whether the plan had been implemented.

Further review of the progress notes revealed that after the above mentioned meeting, resident #026 sustained injuries after two additional incidents of responsive behaviours occurred.

Interview with staff #128 and staff #125 confirmed that the above identified plan was not implemented as the products should have been difficult to access.

The scope is isolated to two residents and the severity is actual harm to the resident in that resident #003 had requested the use of a loaner mobility aid after repeated falls and resident #026 sustained injuries due to exhibiting responsive behaviours. The loaner mobility aid was not provided to resident #003 and her/she continued to experience falls eventually sustaining an injury. Identified resident personal care items remained accessible to resident #026 which resulted in repeated incidents of responsive behaviours. Previous compliance history revealed that a previous written notice (WN) with a voluntary plan of correction (VPC) was issued on April 16, 2015, under critical incident system inspection #2015_298557-0011 related to O. Reg., s. 6 (1) (c). Due to an ongoing non-compliance under O. Reg., s. 6., of the legislation and the actual harm that two residents sustained, a compliance order is warranted. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the residen, to be implemented voluntarily.

WN #2: 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 the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The MOHLTC Action-Line received a complaint related to the fall program in the home. The complainant stated that resident #026 had experienced multiple falls and that most of the falls were preventable. The complainant also reported that resident #026 had a bad fall in the home in 2015, sustaining an injury and that since that day resident #026 was bound to a mobility aid.

Review of resident #026 written plan of care revealed that the resident was at high risk of fall related to a history of falls with injury, and multiple risk factors that included the use of identified medications

Review of the resident progress notes and post fall assessment record, revealed resident #026 had multiple fall incidents and that on two identified dates they were documented as near misses and that post fall assessments had not been completed.

In an interview, staff #104 stated that he/she had documented the fall in June 2015, as a near miss as resident #026 was found sitting on the floor mat beside his/her bed and there was no evidence that the resident had sustained any injury. Staff #104 confirmed that a post fall assessment had not been completed.

In an interview, staff #125 stated that a fall is defined as a change from one level to another, such as from standing, lying, sitting position to the floor and staff should complete a post fall assessment after each fall. Staff #125 further stated that the above mentioned incident was a fall. Staff #125 confirmed that a post-fall assessment had not been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

2. A CIS report was submitted to the Ministry of Health and Long Term Care (MOHLTC) ir which resident #003 experienced a fall on the same day that resulted in a transfer to hospital.

The CIS revealed two fall incidents had occurred on an identified date in July 2016, one in the morning and the second in the afternoon.The CIS also revealed resident #003's pre-fall status as:
-ambulatory status noted to be independent with the use of a mobility aid,
-to use a loaner mobility aid when having difficulty with mobility,
-noted to require extensive assistance with set-up, reminders, and
-queuing with most activities of daily living (ADLs).
The CIS further revealed that the second fall resulted in a transfer to hospital and a diagnosis of an injury. Resident #003's falls history was noted to include previous falls in the past quarter.

Review of resident #003's health record revealed that resident #003 had multiple fall incidents in a two month period. Seven of the fall incidents had been documented as falls, with post fall assessments completed using a clinically appropriate tool specifically designed for falls. The remaining 15 fall incidents had been documented as near misses, a general note or as a behaviour note, with no evidence of post-fall assessments having been completed.

In an interview, staff #126 stated that post fall assessments were not done because the above mentioned incidents had been documented as near misses or under an alternate documentation focus. Staff #126 further stated, that this was, "not good nor right".

In an interview, staff #131 stated that the incident documented on an identified date in June 2016, which he/she had witnessed should have been documented as a fall. Staff #131 further stated that a post-fall assessment using a clinically appropriate tool specifically designed for falls had not been completed.

In an interview, staff #132 stated that he/she had received direction that a near miss was when a resident who had a history of falls, had fall prevention interventions in place and would fall onto a floor mat, that was to be considered a near miss. Staff #132 further stated that this direction had been given sometime in 2014, but could not recall who had given it.

In an interview, staff #125 confirmed that since registered staff had been documenting falls as near misses, post falls assessment had not been completed using a clinically appropriate tool specifically designed for falls for the 15 identified falls mentioned above.

The scope is isolated to two residents and the severity is actual harm related to injuries sustained from repeated fall incidents. Previous compliance history revealed unrelated non-compliances under O. Reg. 79/10. Due to the actual harm the residents sustained, a compliance order is warranted. [s. 49. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

The MOHLTC Action-Line received a complaint related to resident #026. The complainant stated that during a two month period resident #026's condition was progressively deteriorating.

Review of resident #026's weight record for an eleven month period and resident #026's progress notes revealed an ongoing steady weight loss as follows:
-resident #026 had lost an identified per cent of his/her body weight in 30 days,
-staff #106 had assessed the resident for an alternate concern but failed to assess resident #026 weight change,
-resident #026 had lost an identified per cent of his/her body weight in 30 days,
-resident #026 had lost an identified per cent of his/her body weight in 60 days,
-staff #106 completed a quarterly assessment,
-resident #026's family expressed voiced concern over the resident's weight loss as he/she had lost an identified amount of his/her body weight,
-resident #026 had lost an identified per cent of his/her body weight in 30 days,

-dietary changes were ordered after a referral assessment was completed,
-resident #026 had lost an identified per cent of his/her body weight in 30 days, an identified per cent in 90 days, and an identified per cent in 10 months, and
-staff #103 reviewed resident #026's dietary order as per staff #102's request.

In an interview, staff #103 stated that he/she had reviewed and changed dietary orders for resident #026's following a request from staff #102 .Staff #103 confirmed he/she had not assessed resident #026 for weight loss as he/she was new to the position and needed to catch up on the workload.

In an interview with staff #106 stated that his/her assessments were based on the data provided by staff #102 which had not indicated a significant weight change for resident #026, and confirmed that he/she had not assessed resident #026 for significant weight change on the above identified months.

The scope is isolated to one resident and the severity is actual harm to the resident. Resident #026 experienced weight changes in five identified months over a nine month period. Previous compliance history revealed unrelated non-compliance under O. Reg. 79/10. Due to the actual harm the resident sustained, a compliance order is warranted. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #005 triggered for inspection in stage one of the RQI.

Review of the home's policy titled Diet Orders and Temporary or Trial Diets revised September 2011, revealed that temporary or trial diets (including texture and fluid consistency changes) requested by Registered Nursing staff must be reviewed by the RD and the length of the trial, including a reassessment date, must be documented in the progress notes.

Review of resident #005 written plan of care revealed that a dietary referral was sent to the RD) by nursing staff related to a change in resident #005 dietary intake and an underlying health condition that was affecting his/her dietary intake.

Observation conducted by the inspector of resident #005 during a meal service and review of the diet list used for that meal service revealed resident #005 was on an identified diet.

Further review of the resident's progress notes revealed that staff #103 was unable to observe resident #005 after receiving a dietary referral during la meal service. Staff #103 recommended a trial of an alternate diet to optimize dietary intake during time of illness and encourage fluids. Further review of the temporary diet order failed to reveal the length of the trial, including a reassessment date, must be documented in the progress notes.

Review of resident #005's quarterly nutritional assessments for two identified months completed by staff #103 revealed resident #005 was at nutritional risk.

Interviews with staff #143 and staff #100 and staff #122 confirmed that resident #005 had been on a trial of an alternate diet.

In an interview, staff #103 confirmed that the diet order had not included the length of time for the trial diet nor a reassessment date. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #005 triggered for inspection in stage one of the RQI.

Review of the home's policy titled Skin and Wound Care, index number RCSM G-35, dated August 2016, revealed under point number one titled assessments, all residents are to receive a braden scale for predicting pressure sore risk assessment (BSA) by a member of the registered staff. The policy further revealed that the BSA is to be completed:
-within 24 hours of the resident's admission,
-upon any return of the resident from hospital,
-upon any return of the resident from an absence of greater than 24 hours,
-quarterly following admission, and
-as required when significant physical changes have occurred.

Review of the assessments tab for resident #005 revealed the last BSA completed was on an identified date in February 2016, with a score indicating resident #005 was at risk for altered skin integrity.

In an interview, staff #129 stated that a BSA for resident #005 had not been completed quarterly in the past 11 months.

In an interview, staff #125 confirmed that the staff had not completed BSA's for resident #005 quarterly and therefore had not complied with the home's skin and wound care policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. Resident #002 triggered for skin and wound in stage one of the RQI.

Review of the assessment tab revealed that the most recent BSA had been completed for resident #002 on an identified date in May 2016.

In an interview, staff #126 stated that the most recent BSA for resident #002 had been completed seven months earlier. Staff #126 further stated that BSA's are to be completed on admission and quarterly thereafter.

In an interview, staff #125 confirmed that staff had not completed quarterly BSA's on resident #002 and therefore had not complied with the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

4. The MOHLTC Action-Line received a complaint related to the nutrition care and hydration program. The complainant reported that three days after resident #026 was on

a medical leave, the hospital's RD told him/her that the resident had severe underlying health conditions. The complainant also reported that he/she was told by the hospital doctor that the resident had been given, "less than a bottle of water for an entire week."

Review of the home policy titled Hydration Assessment and Management revised September 2011, revealed on point #6 that any resident whose intake is less than 50 per cent or less of their assessed 24 hour fluid requirement as calculated by the RD and who is not on the low fluid list created by the RD, the following actions are taken:
- if the resident's fluid intake continues to be less than 50 per cent or less than their 24 hour requirement for three consecutive days or 72 hours, the registered staff continue to encourage fluid, inform the physician and make a written referral to the RD.

Review of resident #026's written plan of care revealed that he/she was at nutritional risk due to underlying health conditions. Further review of the written plan of care revealed that resident #026's required an identified amount of fluid in a 24 hour period. Staff #106 documented that for resident #026 to achieve optimal hydration status staff were to encourage an identified amount of fluid intake at each meal and at each snack.

Review of resident #026's daily fluids intake record over an identified period revealed that the fluid intake had not been sufficient to achieve optimal hydration status.

Further review of resident #026's written plan of care revealed that he/she was transferred to on a medical leave.

Review of resident #026's health record failed to reveal a three day intake monitoring tool had been completed, a written referral to the RD, and any documentation informing the physician about resident #026's decreased intake.

In an interview, staff#105 stated that resident #026 had been experiencing poor dietary intake.

In an interview, staff #104 stated that resident #026's dietary intake was poor. Staff #104 could not recall whether the resident had been assessed by the RD. Staff #104 also stated that the home policy requires the nursing staff on night shift to review resident daily intake records and document in resident progress notes any concerns to be addressed.

In an interview, staff #122 stated that he/she had worked night shift and had not been

aware that it was that shifts responsibility to review the residents' dietary intake records.

In an interview, staff #112 stated providing fluid to resident #026 had become a challenge due to underlying health conditions and staff cannot force the resident. RN #112 confirmed that a dietary intake record had not been initiated nor a referral to the RD had been sent.

In an interview, staff #125 stated when a resident drinks less than an identified amount for 72 hours, the staff are expected to initiate a three day dietary intake record and a referral should be sent to RD for further assessment. After reviewing resident #026 intake record and progress notes, staff #125 confirmed that the home's policy related to Nutrition and hydration was not complied with by the staff in the home.

The scope is isolated to two residents and the severity is actual harm related to weight loss that both residents experienced. Previous compliance history revealed unrelated non-compliance under O. Reg. 79/10. Due to the actual harm the residents sustained, a compliance order is warranted. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe environment for its residents.

The MOHLTC Action-Line received a complaint related to safety of the residents in the home. The complainant stated that resident #026 was wandering sometimes into other residents' room. The complainant stated that resident #026 on one occasion walked into a co-resident's room and exhibited a responsive behaviour.

Observations by the inspector revealed an open tool box on a treatment cart that contained resident personal care items. At the time of the observation no nursing staff was visible and resident #025 was walking by the opened tool box. Staff #145 was observed in a resident #024's room assisting with grooming.

The staff #121 was walking in the hallway during the time of observation and stated to the inspector that the tool box should be closed and locked if not being supervised. Staff #121 confirmed that leaving resident personal care items in an opened unlocked tool box was not safe. Staff #121 proceeded to close the tool box and provided re-instruction to staff #145 who had left the tool box open, unlocked and unattended.

In an interview, staff #145 stated that he/she usually closes and locks the tool box, but had forgotten as was in a hurry when resident #024 had called for staff #145 to assist with grooming.

In an interview, staff #125 confirmed that leaving resident care items in the hallway unsupervised in an opened unlocked tool box was not safe for the resident [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe for its residents, 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home complete a nutritional assessment for the resident whenever there was a significant change in the resident's health condition.

Resident # 005 triggered for an inpsection in stage one of the RQI.

Review of resident #005 written plan of care revealed a dietary referral was sent to the Registered Dietitian (RD) by nursing staff related to a change in resident #005's dietary intake related to an underlying health condition.

Further review of the resident's progress notes revealed that staff #103 was unable to observe resident #005 after receiving the dietary referral during a meal service. Staff #103 had recommended to trial an alternate diet to optimize intake during times of changes in underlying health conditions and the RD was to follow up and reassess when resident #005 had improved.

Review of the resident #005's plan of care revealed weight changes had occurred at identified monitoring intervals. In addition resident #005 had continued losing body weight consistently over an identified seven month period.

In an interview, staff #103 stated he/she had not assessed the resident when he/she received a dietary referral as resident was placed in isolation precautions. Staff #103 confirmed that he/she had failed to assess resident #005 when care needs had changed. [s. 26. (4) (a),s. 26. (4) (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 registered dietitian who is a member of the staff of the home complete a nutritional assessment for the resident whenever there was a significant change in the resident's health condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

During stage one of the RQI non-compliances related to O. Reg. 79/10, s. 229 (4) were noted and as a result the home's staff training records related to infection prevention and control were reviewed.

Review of the home's infection prevention and control program training record revealed and interview with the staff #128 and staff #125 confirmed that 66 per cent of the staff in the home had not received the annual training on the above identified program in 2015. [s. 76. (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 persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in falls prevention and management.

During stage two of the RQI non-compliance related to O. Reg. 79/10, s. 49. (2), were noted and as a result the home's 2015, staff training records related to falls prevention and management were requested to be reviewed.

In an interview, staff #128 stated that the home did not have a record of staff training records for 2015, related to falls prevention and management. Staff #128 further stated that as a result of not being able to provide staff training records, 100 per cent of direct care staff had not received training in falls prevention and management for 2015.

In an interview, staff #125 stated that in 2015, the home had experienced five outbreaks for a total of 113 days which had made it very difficult to hold group education sessions in the home. As a result no formal training had occurred related to falls prevention and management. Staff #125 further stated that the home had completed one-to-one education with staff when a fall incident had occurred in 2015, however staff #125 could not provide documentation that staff had received this training. [s. 221. (1) 1.]

2. The licensee has failed to ensure that direct care staff were provided training in skin and wound care.

During stage two of the RQI non-compliance related to O. Reg. 79/10, s. 50. (2) (b) (iii), were noted and as a result the home's 2015 staff training records related to skin and wound care were requested to be reviewed.

In an interview, staff #128 stated that the home did not have a record of staff training records for 2015 related to skin and wound care.

In an interview, staff #125 stated that in 2015, the home had experienced five outbreaks for a total of 113 days which had made it very difficult to hold group education sessions in the home. As a result no formal training had occurred related to skin and wound care. [s. 221. (1) 2.]

3. The licensee has failed to ensure that the training is provided related to continence care and bowel management to all staff who provide direct care to residents on either an annual basis, or based on the staff's assessed training needs

During stage two of the RQI non-compliance related to O. Reg. 79/10, r. 51. (2) (a), were identified and as a result the home's staff training records related to continence care management were requested to be reviewed.

Review of the home's continence care program training record revealed and interview with staff #125 confirmed that 66 per cent of the staff in the home had not received the annual training on the above identified program in 2015. [s. 221. (1) 3.]

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 direct care staff were provided training in falls prevention and management, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention and management program was evaluated and updated at least annually in accordance with evidence-based practices and, it there is none, in accordance with prevailing practices.

During stage two of the RQI, non-compliances related to O. Reg. 79/10, s. 49 (2) were identified and as a result the home's annual evaluation of the fall prevention and management program for 2015 was requested to be reviewed.

In an interview, staff #128 stated that he/she could not locate an annual evaluation of the falls prevention and management program for 2015.

In an interview, staff #125 confirmed that an annual evaluation of the falls prevention and management program had not been completed for 2015. [s. 30. (1) 3.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

Resident #009 triggered for an inspection in stage one of the RQI.

Record review of an admission assessment revealed under section M-skin conditions; that resident #009 was coded has having altered skin integrity.

Observations by the inspector revealed that resident #009 had an area of altered skin integrity.

In an interview, resident #009 stated that he/she has had this area of altered skin integrity for quite some time and had been admitted to the long term care home with it.

In interviews staff #117 and #124 stated that resident #009 has had the above mentioned area of altered skin integrity since his/her admission and that it is covered with a dry dressing. Staff #117 and #124 further stated this area of altered skin integrity comes and goes.

In an interview, staff #126 stated that any open areas or areas of redness that maintains or worsens should be referred to the registered dietitian (RD).

In an interview, staff #136 stated that any area of altered skin integrity should be referred to the RD for assessment. Staff #136 confirmed that a referral for resident #009's altered skin integrity had not been sent.

In an interview, staff #125 confirmed that resident #009's area of altered skin integrity had not been assessed by the RD. [s. 50. (2) (b) (iii)]

WN #11: 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. (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence. O. Reg. 79/10, s. 51 (1).

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 continence care and bowel management program provides the treatments and interventions to promote continence.

During stage two of the RQI non-compliance related to O. Reg. 79/10, r. 51. (2) (a), were identified and as a result the continence care management program was inspected.

Review of the home's continence care and bowel management program titled; Continence Care: Bowel and Bladder Management, dated April 2016, failed to review treatments and interventions to promote continence.

In an interview, staff #125 confirmed that the home's continence care and bowel management program had not included the above identified mentioned aspects of the program. He/she stated that program is currently under review. [s. 51. (1) 1.]

2. The licensee has failed to ensure that the resident who is incontinent had received an assessment that:
• includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
• is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident # 006 was triggered for an inspection in stage one of the RQI.

Review of a quarterly assessment revealed that when resident #006 was admitted he/she was usually continent of bowel and frequently incontinent of bladder. Further review revealed that resident #006 had been diagnosed with underlying health conditions affecting mobility.

Review of the assessment tab in the home's documentation system revealed that a continence assessment had not been completed for resident #006 since admission.

Interview with staff #116, staff #110 and staff #112 stated that resident #006 had been incontinent of bladder since admission. Staff #110 and staff #112 confirmed that resident #006 had not been assessed since admission and they further stated that resident #006 should have been assessed on admission and quarterly thereafter.

In an interview, staff #128 stated that the home's expectation is to have all residents assessed for continence upon admission and quarterly thereafter. [s. 51. (2) (a)]

WN #12: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control program evaluation is kept that includes the following:
• the date of the evaluation
• the names of the persons who participated
• a summary of the changes made, and
• the date those changes were implemented.

During stage one of the RQI, non-compliances related to O. Reg. 79/10, s. 229 (4) were noted and as a result Part D of the infection prevention and control inspection protocol was completed.

Review of the home's infection prevention and control program failed to reveal a written record of an annual evaluation for 2015.

In an interview, staff #128, who is also the infection prevention and control program lead stated that the home had multiple outbreaks during 2015, and with the assistance of the public health unit, had an ongoing evaluation throughout the year. Staff #128 stated that the home is currently reviewing the protocol with other sister homes, and confirmed that a written evaluation of the program had not been documented. [s. 229. (2) (e)]

2. The licensee has failed to ensure that there is a designated staff member to co-ordinate the infection prevention and control program with education and experience in infection prevention and control practices including:
(a) infectious disease
(b) cleaning and disinfection
(c) data collection and trend analysis
(d) reporting protocols and
(e) outbreak management

During stage one of the RQI, non-compliances related to O. Reg. 79/10, s. 229 (4) were noted and as a result Part D of the infection prevention and control inspection protocol was completed.

Record review of the education record for staff#128 failed to reveal any education and experience in the infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

In an interview, staff #128 stated his/her knowledge of infection and control program is limited to what he/she was taught in the undergraduate program of nursing and from the home's orientation when hired. Staff #128 confirmed that he/she did not have the above identified required education and experience to lead the home's infection prevention and control program. [s. 229. (3)]

Issued on this 16th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), ANGIE KING (644), JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2016_353589_0019
Log No. / Registre no:	031361-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 6, 2017
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	RIVER GLEN HAVEN NURSING HOME 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Ryan

To ATK CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that care set out in the plan of care is provided to residents as specified in the plan.

The plan shall include, at minimum, the following elements:
-a process to audit that identified care set out in the plan of care for residents is provided as specified,
-an auditing system to ensure that significant monthly weight changes are identified,
-the role and responsibilities of each member of the interdisciplinary team related to weight changes, and
-education to all direct care staff that provides clear direction related to signs and symptoms of dehydration.

Please submit the plan to Joanne.Zahur@ontario.ca no later than February 20, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident.

The MOHLTC Action-Line received a complaint related to safety of the residents in the home. The complainant stated that resident #026 was wandering and once walked into a co-resident's room and exhibited a responsive behaviour.

A multidisciplinary meeting was held to address resident #026's family member's

concerns related to safety as the family was very fearful that the resident would continue to exhibit responsive behaviours within the unit. It is documented that at the end of the meeting, all parties agreed for each resident to be allocated a caddy that would contain their labelled personal items and stored in a secured room. Staff #125 or staff #128 would contact family to advise when the plan indicated above had been fully implemented

Review of the progress notes revealed that resident #026's family member followed up on their concern related to resident #026's safety and asked whether the plan had been implemented.

Further review of the progress notes revealed that after the above mentioned meeting, resident #026 sustained injuries after two additional incidents of responsive behaviours occurred.

Interview with staff #128 and staff #125 confirmed that the above identified plan was not implemented as the products should have been difficult to access.

(589)

2. A critical incident system (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which resident #003 had experienced a fall that resulted in a transfer to hospital.

The CIS report revealed resident #003 sustained two falls on an identified day in July 2016, one in the morning and the second one in the afternoon. On either incident resident #003 was not offered a mobility aid. Further review of the CIS report revealed that the second fall resulted in a transfer to hospital and a subsequent diagnosis of an injury.

The registered nurses association of ontario (RNAO) 2005, nursing best practice guideline-prevention of and fall injuries in the older adult defines a fall as, "an event that results in a person coming to rest inadvertently on the ground or floor or other lower level".

The resident assessment instrument-minimum data set (RAI-MDS) 2.0 considers a fall as:
-when a resident lost balance and would have fallen if staff did not intervene,
-if the fall resulted in an injury,

-if a resident is found on the floor and staff cannot definitively rule out a fall, it should be considered a fall, and
-when the distance to the next lower surface is not a factor. If a resident rolls onto floor from a mattress placed on the floor, it is still a fall.

Review of resident #003's written plan of care revealed that staff #119 had implemented the use of a loaner mobility aid. This mobility aid was to be used as an intervention to reduce the risk of falls when the resident was experiencing with mobility..

Review of resident #003's health record revealed that resident #003 had multiple fall incidents between a two month period. Seven of the incidents had been documented as falls, the remaining 15 incidents had been documented as near misses, a general note or as a behaviour note. These included:

Further review of resident #003 progress notes revealed the following:
- staff #119 documented ongoing monitoring of the effectiveness of the use of the mobility aid in reducing falls.
- staff #126 documented resident #003 had requested the mobility aid as he/she had sustained four falls on the same day. Staff responded by encouraging resident #003 to take his/her time, and keep his/her current mobility aid close during ambulation and did not provide the loaner mobility aid as requested.
- staff #131 documented that resident #003 had sustained another fall and staff continued to provide encouragement to ambulate with his/her current mobility aid.
- resident #003 sustained a fall and stated, he/she could not stand anymore.
- later on the on the same day, resident #003 had a second fall as a result of losing control of his/her mobility aid.

On three identified dates a review of resident #003's progress notes failed to reveal that the loaner mobility aid had not been offered to ensure the resident's safety.

In interviews, staff #119, staff #126 and #131 stated the loaner mobility aid had not been provided to resident #003 as specified in the plan of care when he/she had been experiencing difficulty with mobility using his/her current mobility aid.

In an interview, staff #125 confirmed that staff had not provided care as set out in the plan of care to resident #003. As a result, resident #003 continued to

experience falls and sustained an injury.

The scope is isolated to two residents and the severity is actual harm to the resident in that resident #003 had requested the use of a wheelchair after repeated falls and resident #026 sustained injury to his/her mouth from eating razors.The wheelchair was not provided to resident #003 and her/she continued to experience falls eventually sustaining a fracture. Identified resident personal care items remained accessible to resident #026 which resulted in repeated incidents of responsive behaviours. Previous compliance history revealed that a previous written notice (WN) with a voluntary plan of correction (VPC) was issued on April 16, 2015, under critical incident system inspection #2015_298557-0011 related to O. Reg., s. 6 (1) (c). Due to an ongoing non-compliance under O. Reg., s. 6., of the legislation and the actual harm that two residents sustained, a compliance order is warranted. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that interventions set out in the plan of care is provided to residents as specified in the plan.

The plan shall include, at minimum, the following elements:

-a plan to ensure that direct care staff receive falls prevention and management training on an annual basis,
-the training shall include the definition of a fall, and a near miss, and the difference between the two incidents, and
-a system to audit resident fall incidents and that post fall assessments are completed.

Please submit the plan to Joanne.Zahur@ontario.ca no later than February 20, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A CIS report was submitted to the Ministry of Health and Long Term Care (MOHLTC) in which resident #003 experienced a fall on the same day that resulted in a transfer to hospital.

The CIS revealed two fall incidents had occurred on an identified date in July 2016, one in the morning and the second in the afterhoon.The CIS also revealed resident #003's pre-fall status as:
-ambulatory status noted to be independent with the use of a mobility aid,
-to use a loaner mobility aid when having difficulty with mobility,
-noted to require extensive assistance with set-up, reminders, and
-queuing with most activities of daily living (ADLs).
The CIS further revealed that the second fall resulted in a transfer to hospital and a diagnosis of an injury. Resident #003's falls history was noted to include previous falls in the past quarter.

Review of resident #003's health record revealed that resident #003 had multiple fall incidents in a two month period. Seven of the fall incidents had been documented as falls, with post fall assessments completed using a clinically appropriate tool specifically designed for falls. The remaining 15 fall incidents had been documented as near misses, a general note or as a behaviour note, with no evidence of post-fall assessments having been completed.

In an interview, staff #126 stated that post fall assessments were not done because the above mentioned incidents had been documented as near misses or under an alternate documentation focus. Staff #126 further stated, that this was, "not good nor right".

In an interview, staff #131 stated that the incident documented on an identified date in June 2016, which he/she had witnessed should have been documented as a fall. Staff #131 further stated that a post-fall assessment using a clinically appropriate tool specifically designed for falls had not been completed.

In an interview, staff #132 stated that he/she had received direction that a near miss was when a resident who had a history of falls, had fall prevention interventions in place and would fall onto a floor mat, that was to be considered a near miss. Staff #132 further stated that this direction had been given sometime in 2014, but could not recall who had given it.

In an interview, staff #125 confirmed that since registered staff had been documenting falls as near misses, post falls assessment had not been completed using a clinically appropriate tool specifically designed for falls for the 15 identified falls mentioned above.

(589)

2. The MOHLTC Action-Line received a complaint related to the fall program in the home. The complainant stated that resident #026 had experienced multiple falls and that most of the falls were preventable. The complainant also reported that resident #026 had a bad fall in the home in 2015, sustaining an injury and that since that day resident #026 was bound to a mobility aid.

Review of resident #026 written plan of care revealed that the resident was at high risk of fall related to a history of falls with injury, and multiple risk factors that included the use of identified medications

Review of the resident progress notes and post fall assessment record, revealed resident #026 had multiple fall incidents and that on two identified dates they were documented as near misses and that post fall assessments had not been completed.

In an interview, staff #104 stated that he/she had documented the fall in June 2015, as a near miss as resident #026 was found sitting on the floor mat beside his/her bed and there was no evidence that the resident he/she had sustained an injury. Staff #104 confirmed that a post fall assessment had not been completed.

In an interview, staff #125 stated that a fall is defined as a change from one level to another, such as from standing, lying, sitting position to the floor and staff should complete a post fall assessment after each fall. Staff #125 further stated that the above mentioned incident was a fall. Staff #125 confirmed that a post-fall assessment had not been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The scope is isolated to two residents and the severity is actual harm related to injuries sustained from repeated fall incidents. Previous compliance history revealed unrelated non-compliances under O. Reg. 79/10. Due to the actual harm the residents sustained, a compliance order is warranted. (502)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2017

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month,
2. A change of 7.5 per cent of body weight, or more, over three months,
3. A change of 10 per cent of body weight, or more, over 6 months, and
4. Any other weight change that compromises their health status.

Grounds / Motifs :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

The MOHLTC Action-Line received a complaint related to resident #026. The complainant stated that during a two month period resident #026's condition was progressively deteriorating.

Review of resident #026's weight record for an eleven month period and resident #026's progress notes revealed an ongoing steady weight loss as follows:
-resident #026 had lost an identified per cent of his/her body weight in 30 days,
-staff #106 had assessed the resident for an alternate concern but failed to assess resident #026 weight change,
-resident #026 had lost an identified per cent of his/her body weight in 30 days,
-resident #026 had lost an identified per cent of his/her body weight in 60 days,
-staff #106 completed a quarterly assessment,
-resident #026's family expressed voiced concern over the resident's weight loss as he/she had lost an identified amount of his/her body weight,
-resident #026 had lost an identified per cent of his/her body weight in 30 days,
-dietary changes were ordered after a referral assessment was completed,
-resident #026 had lost an identified per cent of his/her body weight in 30 days, an identified per cent in 90 days, and an identified per cent in 10 months, and
-staff #103 reviewed resident #026's dietary order as per staff #102's request.

In an interview, staff #103 stated that he/she had reviewed and changed dietary orders for resident #026's following a request from staff #102 .Staff #103 confirmed he/she had not assessed resident #026 for weight loss as he/she was new to the position and needed to catch up on the workload.

In an interview with staff #106 stated that his/her assessments were based on the data provided by staff #102 which had not indicated a significant weight change for resident #026, and confirmed that he/she had not assessed resident #026 for significant weight change on the above identified months.

The scope is isolated to one resident and the severity is actual harm to the resident. Resident #026 experienced weight changes in five identified months over a nine month period. Previous compliance history revealed unrelated non-compliance under O. Reg. 79/10. Due to the actual harm the resident sustained, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2017

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the plan, policy, procedure, strategy or system was complied with.

The plan shall include, at minimum, the following elements:
-reassessment of all residents identified at high risk for dehydration,
-an auditing system to ensure that significant monthly weight changes are identified,
-the role and responsibilities of each member of the interdisciplinary team related to weight change and dehydration is clearly identified, and
-an auditing system to ensure the referral process identified in the home's policy is complied with.

Please submit the plan to Joanne.Zahur@ontario.ca no later than February 20, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The MOHLTC Action-Line received a complaint related to the nutrition care and hydration program. The complainant reported that three days after resident #026 was on a medical leave, the hospital's RD told him/her that the resident had

severe underlying health conditions. The complainant also reported that he/she was told by the hospital doctor that the resident had been given, "less than a bottle of water for an entire week."

Review of the home policy titled Hydration Assessment and Management revised September 2011, revealed on point #6 that any resident whose intake is less than 50 per cent or less of their assessed 24 hour fluid requirement as calculated by the RD and who is not on the low fluid list created by the RD, the following actions are taken:
- if the resident's fluid intake continues to be less than 50 per cent or less than their 24 hour requirement for three consecutive days or 72 hours, the registered staff continue to encourage fluid, inform the physician and make a written referral to the RD.

Review of resident #026's written plan of care revealed that he/she was at nutritional risk due to underlying health conditions. Further review of the written plan of care revealed that resident #026's required an identified amount of fluid in a 24 hour period. Staff #106 documented that for resident #026 to achieve optimal hydration status staff were to encourage an identified amount of fluid intake at each meal and at each snack.

Review of resident #026's daily fluids intake record over an identified period revealed that the fluid intake had not been sufficient to achieve optimal hydration status.

Further review of resident #026's written plan of care revealed that he/she was transferred to on a medical leave.

Review of resident #026's health record failed to reveal a three day intake monitoring tool had been completed, a written referral to the RD, and any documentation informing the physician about resident #026's decreased intake.

In an interview, staff#105 stated that resident #026 had been experiencing poor dietary intake.

In an interview, staff #104 stated that resident #026's dietary intake was poor. Staff #104 could not recall whether the resident had been assessed by the RD. Staff #104 also stated that the home policy requires the nursing staff on night shift to review resident daily intake records and document in resident progress

notes any concerns to be addressed.

In an interview, staff #122 stated that he/she had worked night shift and had not been aware that it was that shifts responsibility to review the residents' dietary intake records.

In an interview, staff #112 stated providing fluid to resident #026 had become a challenge due to underlying health conditions and staff cannot force the resident. RN #112 confirmed that a dietary intake record had not been initiated nor a referral to the RD had been sent.

In an interview, staff #125 stated when a resident drinks less than an identified amount for 72 hours, the staff are expected to initiate a three day dietary intake record and a referral should be sent to RD for further assessment. After reviewing resident #026 intake record and progress notes, staff #125 confirmed that the home's policy related to Nutrition and hydration was not complied with by the staff in the home.

(502)

2. Resident #005 triggered for inspection in stage one of the RQI.

Review of the home's policy titled Diet Orders and Temporary or Trial Diets revised September 2011, revealed that temporary or trial diets (including texture and fluid consistency changes) requested by Registered Nursing staff must be reviewed by the RD and the length of the trial, including a reassessment date, must be documented in the progress notes.

Review of resident #005 written plan of care revealed that a dietary referral was sent to the RD) by nursing staff related to a change in resident #005 dietary intake and an underlying health condition that was affecting appetite.

Observation conducted by the inspector of resident #005 during a meal service and review of the diet list used for that meal service revealed resident #005 was on an identified diet.

Further review of the resident's progress notes revealed that staff #103 was unable to observe resident #005 after receiving a dietary referral during la meal service. Staff #103 recommended a trial of an alternate diet to optimize dietary

intake during time of illness and encourage fluids. Further review of the temporary diet order failed to reveal the length of the trial, including a reassessment date, must be documented in the progress notes.

Review of resident #005's quarterly nutritional assessments for two identified months completed by staff #103 revealed resident #005 was at nutritional risk.

Interviews with staff #143 and staff #100 and staff #122 confirmed that resident #005 had been on a trial of an alternate diet.

In an interview, staff #103 confirmed that the diet order had not included the length of time for the trial diet nor a reassessment date.

The scope is isolated to two residents and the severity is actual harm related to weight loss that both residents experienced. Previous compliance history revealed unrelated non-compliance under O. Reg. 79/10. Due to the actual harm the residents sustained, a compliance order is warranted. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

Service Area Office /
Bureau régional de services : Toronto Service Area Office