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
Sep 21, 2015	2015_217137_0038	019817-15	Resident Quality Inspection

Licensee/Titulaire de permis

SHANTI ENTERPRISES LIMITED
600 White's Road PALMERSTON ON N0G 2P0

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

ROYAL TERRACE
600 White's Road PALMERSTON ON N0G 2P0

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

MARIAN MACDONALD (137), DOROTHY GINTHER (568), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 17-21 and August 24-26, 2015.

Two complaint inspections were completed during the Resident Quality Inspection (RQI) under Log # 019876-15, related to call bell response time/falls prevention and Log # 022497-15, related to alleged care provision neglect

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Director of Dietary and Environmental Services, Director of Life Enrichment, Office Manager, Registered Dietitian, Physiotherapist, Physiotherapist Assistant, RAI Coordinator, three Registered Nurses, five Registered Practical Nurses, 11 Personal Support Workers (PSW's), one Maintenance Worker, one Housekeeper, one Life Enrichment Aide, one Dietary Aide, four Family Members and 40+ Residents.

The inspectors also toured all resident home areas, common areas, medication storage area, observed dining service, care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures, staff education records and various meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Residents' Council
Responsive Behaviours

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

Findings/Faits saillants :

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

A review of the Minimum Data Set (MDS) assessments, for an identified resident, revealed the resident's care needs changed since admission and a review of the care plan, revealed the plan had not been revised to reflect the resident's current care needs. A Personal Support Worker confirmed the resident's care needs had changed.

During an interview, the Director of Care confirmed the care plan had not been revised and the expectation was that care plans be reviewed and revised when residents' care needs changed. [s. 6. (10) (b)]

2. A review of the progress notes, for an identified resident, revealed that the care set out in the plan was no longer necessary and the plan of care had not been reviewed or revised.

The Director of Care confirmed that the care set out in the plan was no longer necessary and the plan of care had not been reviewed or revised, as well as the expectation was that care plans be reviewed and revised when residents' care needs changed. [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 each 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. A written notification of non-compliance and a voluntary plan of correction were previously issued on June 24, 2014 under Log # L-000632-14 and Inspection # 2014_217137_0018, related to the the home, furnishings and equipment not being maintained in a safe condition and in a good state of repair.

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

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies, such as damaged wooden bathroom/ bedroom doors and walls, in 19/37 (51%) of resident rooms.

During an interview with the Director of Dietary and Environmental Services, the identified deficiencies were confirmed, as well as the expectation that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behavior program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

During a record review, there was no documented evidence that an annual review or evaluation of the responsive behavior program was completed.

During an interview, the lead for the responsive behavior program shared that the program was still in it's early stages and confirmed that an annual evaluation was not completed. [s. 53. (3) (b)]

2. The licensee has failed to ensure that behavioral triggers have been identified for the resident demonstrating responsive behaviors.

The Minimum Data Set (MDS) assessment, for an identified resident, indicated that the resident exhibited persistent anger with self and expressed unrealistic fears on almost a daily basis. The resident was resistive to care and the responsive behaviors were not easily altered.

During a review of the plan of care, there was no documented evidence that the resident was resistive during the provision of care and there were no triggers identified for the responsive behaviors.

The Director of Care confirmed that the identified resident was frequently resistive to care and that behavioral triggers had not been identified for the resident. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behavior program is evaluated annually and updated in accordance with evidence-based practices or prevailing practices and that behavioral triggers are identified for the resident demonstrating responsive behaviors, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. A written notification of non-compliance was previously issued on June 24, 2014 under Log # L-000632-14 and Inspection # 2014_217137_0018, related to not seeking the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The licensee has failed to ensure to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

A review of the Residents' Council meeting minutes revealed there was no documented evidence that the licensee seeks the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Director of Life Enrichment, it was confirmed the Residents' Council does not have input into the development or implementation of the Satisfaction Survey. [s. 85. (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 to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #5: 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).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

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

An identified resident was observed sitting in a tilt wheelchair, with a front fastening seat belt in place. The seat belt was noted to be twisted and applied loosely.

During a second observation, the same resident was observed sitting in the wheelchair, tilted approximately 40 degrees, with a front fastening seat belt in place. The belt was loose, with more than a full hands breadth between the belt and the resident and it lay across the resident's thighs.

The Director of Life Enrichment confirmed that the seat belt was not applied correctly and that it may pose a safety risk for the resident. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the following are documented:
what alternatives were considered and why those alternatives were inappropriate and all assessment, reassessment and monitoring, including the resident's response.

During two observations, an identified resident, was observed seated in a tilt wheelchair, with a front fastening seat belt in place.
When the resident was asked if he/she could remove the seat belt, there was no response.

A Personal Support Worker shared that the resident would not be able to remove the seat belt or independently upright the tilted wheelchair, without assistance.

A record review revealed a physician's order for a tilt wheelchair, lap belt and table top for safety and positioning in the wheelchair.
A consent, for the application of a lap belt and tilt wheelchair, was signed by Power of Attorney.

There was no documented evidence of an initial assessment related to the application of the physical devices, including alternatives considered or trialed and the resident's response to these alternatives.
The Treatment Administration Record did not include documentation by registered staff, to indicate that the resident's condition was evaluated and the effectiveness of the restraining device was assessed each shift.

The Director of Life Enrichment confirmed that there were no documented assessments with regards to the application of the lap belt and tilt wheelchair, including what alternatives were considered, and the resident's response to these alternatives. [s. 110. (7)]

3. During two separate observations, another identified resident was observed sitting in his/her wheelchair, with a front fastening seat belt in place.
When asked, the resident was not able to independently release or remove the lap belt.

A record review revealed a physician's order for a seat belt to be applied when the resident is up in his/her wheelchair.
A consent, for the application of a lap belt, tilt wheelchair and table, was signed by Power of Attorney (POA).
There was no documented evidence of an initial assessment related to the application of the physical devices, including alternatives considered or trialed and the resident's response to these alternatives.
There was no documented evidence of the alternatives considered.

During interviews, with the Director of Life Enrichment and one of the leads for the restraints program, it was revealed that the home had an Initial Restraints Assessment on Point Click Care (PCC) but that the assessment had not been completed for all residents that had a physical device applied. The staff member shared that they just found a monthly review assessment on PCC and have initiated it this month.
Prior to this they did not have a reassessment tool.

The Director of Life Enrichment confirmed that there were no documented assessments with regards to the application of the seat belt, for the identified resident, including what alternatives were considered, and the resident's response to these alternatives. [s. 110. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that physical devices are applied in accordance with the manufacturer's instructions, if any and, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis; and that at least once every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

During a review of the home's Performance Improvement Reports and Quality Improvement documentation there was no evidence of a monthly analysis of the restraining of residents by the use of a physical device nor was there an annual evaluation of the restraints program with recommended changes and improvements to minimize restraining and to ensure that any restraining was done in accordance with the Act and this regulation.

Interviews, with the Director of Life Enrichment and one of the leads for the restraints program, confirmed that the home has not currently conducting a monthly analysis of the restraining of residents by a physical device and there was no annual evaluation of the restraints program. [s. 113.]

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 an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis; and that at least once every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation, to be implemented voluntarily.

WN #7: 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:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that training was provided for all staff who applied physical devices or who monitored residents restrained by a physical device, including application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

An identified resident was observed sitting in a wheelchair, with a front fastening seat belt in place. The belt was loose, more than a hands breadth between the belt and the resident, and it was lying across the resident's thighs.
During two observations, another identified resident, was observed sitting in a tilt wheelchair, with a front fastening seat belt in place.
A space, more than a full hands breadth, was observed between the belt and the resident and the belt lay across the resident's thighs.

During interviews, with three Personal Support Workers, they shared that when applying physical devices, such as seat belts, they use common sense.
The PSW's could not recall being educated as to how the seat belts should be applied but do try to ensure that the belts are not too tight or too loose.
Two of the PSW's indicated that if they can slide the flat of their hand under the belt then that is usually acceptable.

An interview, with the Director of Life Enrichment, revealed that education related to the application of physical devices was provided annually by Mackhall Mobility.
The education was hands-on and the home did not have a record of what was covered in the in-service.
Records indicated that the last in-service provided by Mackhall Mobility was May 15, 2014. There were no scheduled in-services, related to restraint use/application, on the current education calendar for 2015.

An interview, with the Director of Care, revealed that newly hired staff attend a full day of general orientation, followed by shift orientation, before starting work in the home.
The orientation included a review of the home's Restraint Policy.
The home's policy, entitled Restraints, did not provide direction as to the application of physical devices, such as seat belts.

The Director of Care confirmed that not all staff, who apply physical devices used to restrain residents, were provided training with respect to the proper application, prior to commencing employment in the home. [s. 221. (1) 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 training is provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including application of these physical devices, use of these physical devices, and potential dangers of these physical devices, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home were kept at the home.

A record review, for an identified resident, revealed the plan of care was updated and revised by the Physiotherapist but there was no documented evidence of a physiotherapist assessment being completed.

A review, of the Physiotherapist's assessment binder, revealed no evidence of a physiotherapy assessment being completed.

During an interview, the Physiotherapist confirmed that the plan of care for the identified resident was revised, after an assessment, but the assessment was not in the physiotherapy binder and that physiotherapy assessments/reassessments are not kept in the home. [s. 232.]

2. A record review revealed that an identified resident sustained an injury and the care plan indicated that the resident was being seen by physiotherapy for gait training and exercise.
There was no documented evidence, in the resident's clinical record, of any physiotherapy assessments or reassessments.

An interview, with the Director of Life Enrichment, revealed that the physiotherapist was in the home one day each week to conduct resident assessments, reassessments and revise treatment care plans but was unsure where the physiotherapy documentation was being kept.
The Physiotherapy Assistant acknowledged that the Physiotherapist did not keep documentation, with respect to resident assessments, at the home.

The Physiotherapist confirmed being in the home one day each week and that resident assessments and reassessments were not being kept at the home. [s. 232.]

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 records of the residents of the home are kept at the home, to be implemented voluntarily.

Issued on this 21st day of September, 2015

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

Original report signed by the inspector.