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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2018	2018_720130_0011	009810-18	Resident Quality Inspection

Licensee/Titulaire de permis

Shalom Village Nursing Home
60 Macklin Street North HAMILTON ON L8S 3S1

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

Shalom Village Nursing Home
70 Macklin Street North HAMILTON ON L8S 3S1

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

GILLIAN HUNTER (130), DIANNE BARSEVICH (581), LISA BOS (683), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 17, 18, 23, 24, 25, 28, 29, 30, 31, June 1, 5, 6 and 7, 2018.

Please note: Inspector, Maria McGill (728) attended this inspection during orientation.

The following onsite inquiries were conducted concurrently with this RQI:

025196-17 related to CI 2775-000007-17, related to abuse and Complaint 003117-17 related to medication administration.

The following critical incident inspections were conducted concurrently with this RQI:

033047-16 (2775-000020-16), 029352-17 (2775-000010-17), 025743-17 (2775-000008-17) and 000245-18 (2775-000011-17) related to falls management and prevention, 033933-16 (2775-000023-16) and 004281-17 (2775-000004-17) related to abuse, 011938-18 (2775-000005-18) related to abuse and responsive behaviours and 004338-17 (2775-000003-17) related to plan of care.

The following complaint inspection was conducted concurrently with this RQI:

033877-16 (IL-49257-HA) related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Executive Coach of Resident Care (ECRC), Resident Assessment Instrument (RAI) Coordinator, Life and Transition Coach, registered staff, personal support workers (PSW's), Physiotherapist, President of Residents' Council, President of Family Council and residents and famillies.

During this inspection, the home was toured, care was observed, medication administration was observed, clinical records, incident reports, investigation files and relevant policies and procedures were reviewed.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
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
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **4 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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure residents were protected from abuse by anyone and free

from neglect by the licensee or staff in the home.

O. Reg. 79/10, s. 2(1) defines sexual abuse as any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A) On an identified date in 2017, the home submitted Critical Incident report that on an identified date in 2017, resident #052 demonstrated a responsive behaviour toward resident #052. The Administrator confirmed in an interview on a date in 2018, that resident #052 had known responsive behaviours.

Resident #052's clinical record identified on an identified date in 2016, that staff #107 documented in a progress note that resident #052 was seen demonstrating a responsive behaviour toward resident #053.

The progress notes also stated that on a second identified date in 2016, staff #107 recorded another incident where resident #052 was seen demonstrating a responsive behaviour toward resident #053.

A third incident was recorded by staff #106 in 2016, whereby resident #052 was seen demonstrating a responsive behaviour toward resident #053.

On the identified dates, resident #053 was not protected from abuse by resident #052.

Please note: This non compliance was issued as a result of CI inspection which was conducted concurrently with this RQI. (#130).

B) On an identified date in 2017, the home submitted a Critical Incident to report that on a date in 2017, resident #052 was seen demonstrating a responsive behaviour towards resident #001. The Administrator confirmed in an interview in 2018, that resident #001 was upset as a result of the incident. Resident #001 recalled the incident during an interview on a date in 2018 and expressed they did not wish the incident to happen again.

On an identified date in 2018, it was confirmed by the home's investigation and in an interview with the Administrator that resident #052 demonstrated a responsive behaviour towards resident #001.

On an identified date in 2017, resident #001 was not protected from abuse by resident #052.

Please note: This non compliance was issued as a result of CI inspection which was conducted concurrently with this RQI. (#130). [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied: alternatives to the use of a PASD had been considered, and tried where appropriate, the use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASD's that would be effective to assist the resident with the routine activity of living, the use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, and the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with

authority to give that consent.

A) On an identified date in 2017, resident #002 was observed in their wheelchair, in a specific position. A review of the progress notes indicated the wheelchair belonged to the home and that the resident had been using the wheelchair since 2013. A review of the plan of care identified there was no documentation related to alternatives considered and tried, or approval for its use and no consent signed from the SDM for the specific wheelchair as a PASD with restraining effects.

In an interview, RPN #124 stated the resident required the wheelchair for repositioning for a specific reason. They confirmed there was no documentation for the use of the wheelchair as a PASD or for alternatives tried in the resident's plan of care, no documented approval for the device and no consent signed from the SDM for the wheelchair as a PASD. (581).

B) On an identified date in 2017, resident #008 was observed positioned in their specific wheelchair. A review of the plan of care identified there was no documentation related to alternatives considered and tried, or approval for its use and no consent signed from the SDM for the specific wheelchair as a PASD with restraining effects.

In an interview, PSW #128 stated that the resident was in the wheelchair for specific needs and was repositioned at various times during the day by staff.

Interview with RPN #109 stated that the resident was seated in a specific wheelchair for specific needs. They confirmed there was no documentation for the use of the specific wheelchair as a PASD or for alternatives tried in the resident's plan of care, no documented approval for the device and no consent signed from the SDM for the wheelchair as a PASD. (581). [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living is included in a resident's plan of care only if all of the following are satisfied: alternatives to the use of a PASD have been considered, and tried where appropriate, the use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASD's that will be effective to assist the resident with the routine activity of living, the use of the PASD has been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, and the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent., 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. (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 :

The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included: assessments, reassessments, interventions, and documentation of the resident's responses to the interventions.

A) The Quarterly Minimum Data Set (MDS) assessment completed for resident #052 on an identified date in 2016, under a specific section was coded zero, indicating there were no behaviours observed during the seven day observation period and indicated the resident's behaviour status had not changed as compared to their status of 90 days or since the last assessment, which was completed on a specific date in 2016.

Progress notes reviewed during the 90 days since the last assessment completed on a specific date in 2016, indicated the resident had demonstrated a specific responsive behaviour on at least two occasions and another behaviour on at least one occasion. The resident had known responsive behaviours dating back to 2013.

The Modified RAP triggered for the specific section during an identified assessment period in 2016 did not reflect exhibited responsive behaviours and stated, no objectives specified.

On a specified date in 2018, RAI Coordinator #117 confirmed in an interview that there were no other assessments completed related to responsive behaviours other than the MDS assessment, which captured responsive behaviours exhibited during the observation period. Responsive behaviours exhibited by the resident outside of the observation period were not assessed and therefore there were no interventions implemented.

On an identified date in 2017, the home submitted a Critical Incident to report that on an identified date in 2017, cognitively impaired resident #053 was seen demonstrating responsive behaviours towards resident #001. The Administrator confirmed in an interview, that the responsive behaviour was non-consensual in both incidents.

Please note: This non compliance was issued as a result of CI inspection which was conducted concurrently with this RQI. (130). [s. 53. (4) (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 actions taken to meet the needs of the resident with responsive behaviours include: assessments, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

A) According to the clinical record, resident #052 had a known history of responsive behaviours. On an identified date in 2016, staff #107 documented that resident #052, was seen demonstrating responsive behaviours towards resident #053.

On an identified date in 2016, RAI Coordinator #107, documented that resident #052 was seen demonstrating responsive behaviours towards resident #053.

On another identified date in 2016, staff #106 documented that resident #052 was seen demonstrating responsive behaviours towards resident #053.

Progress notes reviewed during the 90 days since the last assessment completed on a specified date in 2016, indicated that resident #052 was seen demonstrating responsive behaviours towards resident #053 on at least two occasions; however, there were no changes to interventions or new strategies considered over a nine month period from 2016 until 2017.

On an identified date in 2017, the home submitted a Critical Incident to report that on an identified date in 2017, resident #052 was seen demonstrating responsive behaviours towards resident #053 and later the same day, resident #052 was seen demonstrating responsive behaviours towards resident #001.

On an identified date in 2018, staff #117 confirmed in an interview that there were no changes to interventions or new strategies considered with respect to responsive behaviours and that steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents over a nine month period from 2016 until 2017, when subsequent incidents had occurred.

Please note: This non compliance was issued as a result of CI inspection, which was conducted concurrently with this RQI. (130). [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that can potentially trigger such altercations, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 :

The licensee failed to ensure that there was a written plan of care for each resident that set out as planned care for the resident.

A) The ECRC of the home submitted a CIS Report in 2017 which identified that resident #031 had an unwitnessed fall with injury. The hospital provided the resident with an intervention that was to be used at specified times.

A review of the physician orders identified that the resident was to have the intervention and that it was not to be removed. On an identified date in 2018, PSW #110 who

provided care at the time of the injury was interviewed and stated the resident used the intervention after the injury. A review of the written plan of care identified the resident hac the injury; however, did not identify the intervention. In an interview with RPN #106 on a specified date in 2018, they stated the resident required the intervention after the injury and confirmed the written plan of care did not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Review of the MDS assessment completed on an identified date in 2018, identified that resident #001 had an impairment that required an adaptive device. A review of the Resident Assessment Protocol (RAP) during the same time period identified the resident used the adaptive device occasionally for a specific activity and sometimes for another activity. The resident stated in an interview they did have the adaptive device and sometimes used if for the identified activity and that they could use the device without assistance. In an interview PSW #122 verified that the resident used the adaptive device for a specific activity, but not all the time and that they could use it without assistance. The RAI Coordinator confirmed in an interview that the resident used the adaptive device sometimes and that the MDS assessment and the RAP assessment were not integrated and consistent with each other.

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

A) On an identified date in 2018, an identified resident's room was observed; the resident was not in the bed and there were two interventions in place. Review of the current written plan of care identified the interventions and how and when it was to be used. In an interview PSW #110 stated that the resident got up in the morning on the night shift on an identified date and stated that the intervention should have been removed. Interview with RPN #106 and review of the written plan of care confirmed that the intervention was to be removed at a specific time.
They confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

Please note: This non compliance was issued as a result of critical incident system inspection, which was conducted concurrently with the RQI. (581).

B) Resident #051 was admitted to the home in 2016 and on that day nursing staff developed the 24-Hour Care Plan which identified care requirements.

When interviewed, resident #051's SDM said that when they came to visit the resident on a specified date in 2016, they found the resident in unsatisfactory condition. The SDM confirmed that at that time resident #051 was able to communicate with them accurately and in detail regarding what had happened and told the SDM that they were not provided with assistance they required. Resident #051 told the SDM that they had woken up on the identified date in 2016 and did their own care without assistance.

The above noted information was consistent with information provided to the Director in a Critical Incident Report submitted by the ECRC in 2016, and amended several days later.

When interviewed and following a review of interview notes documented by the ECRC, PSW #114, who would have been responsible for providing care to the resident on the identified date in 2016, said the information they provided to the ECRC, when interviewed following the above noted incident was accurate. PSW #114 confirmed resident #051 had not been placed on the PSW assignment sheet and they did not provide care or supplies to the resident.

Resident #051, their SDM, investigative notes maintained by the home, a critical incident submitted to the Director and PSW staff #114 confirmed that the resident did not receive the care as specified in the plan of care on the evening shift on identified date in 2016 and the morning of a second identified date in 2016.

Care set out in the plan of care for resident #051 was not provided to the resident as specified in the plan in 2016.

PLEASE NOTE: The above noted non-compliance related to resident #051 was identified while inspecting a Compliant and a related CI that were conducted concurrently with this RQI. (129).

C) A review of critical incident submission, internal investigation notes and staff interviews identified that on an identified date in 2018, resident #020 asked PSW #116 for assistance with an activity PSW #116 identified that their partner, PSW #115, was on the other side and would assist them as soon as they could. When PSWs #116 and #115

arrived in resident #020's room to provide assistance, PSW #115 identified to the resident what they were going to do. The resident stated that they needed specific assistance and PSW #115 responded that they would provide different assistance. The resident was not provided with the help they requested.

A review of the clinical record for resident #020 identified that they preferred to go to bed at a specified time. This intervention was initiated on an identified date 2017.

A review of the home's internal investigation notes identified an interview with resident #020 where they indicated that PSW #115 entered the room and spoke to them in an unprofessional manner and that they tried to please them. As per the investigation notes, Resident #020 identified that PSW #115 did assist them to bed at their preferred time and indicated that they thought they did not have a choice.

In an interview with the ECRC on an identified date in 2018, they confirmed that the care set out in the plan of care for resident #020, was not provided to the resident on the identified date in 2018.

Please note: This non compliance was issued as a result of critical incident inspection which was conducted concurrently with the RQI. (683). [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A) The ECRC of the home submitted a CIS Report in 2017, which identified that resident #031 sustained a fall with injury. The hospital provided the resident with a custom adaptive device which was to be worn at specified times.

A review of the plan of care identified that an intervention was implemented for safety. On an identified date in 2018, PSW #110 was interviewed and stated the resident did not have the intervention as it was no longer required. In an interview with RPN #106 on an identified date in 2018, they stated that the safety intervention was no longer required and confirmed that the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary.

Please note: This non-compliance was issued as a result of CI inspection, which was conducted concurrently with the RQI. (581)

B) The ECRC of the home submitted a CIS Report on an identified date in 2017, which identified on a specific date in 2017, resident #032 sustained a fall with injury. The resident had a history of falls prior to admission to the home and had falls interventions in place.

A review of the plan of care for resident #032 identified they required two specific intervention in place to ensure safety. In an interview on an identified date in 2018, with PSW #112 stated for approximately four months, the resident did not have the intervention in place. On an identified date in 2018, RPN #113 was interviewed and stated the resident no longer required the intervention. They confirmed that the plan of care was not reviewed and revised when the care set out in the plan was no longer necessary. (581).

Please note: This non-compliance was issued as a result of CI, which was conducted concurrently with the RQI.

C) The ECRC of the home submitted a CIS Report on an identified date in 2017, which stated on a specified date in 2017, resident #011 sustained a fall with injury.

A review of the plan of care for resident #011 identified they were transferred with two person assistance using a device. On an identified date in 2018, the Physiotherapist was interviewed and stated the resident required two person assistance with a device after their injury but following a reassessment on an identified date, the level of assistance changed to one person assistance.

In an interview on an identified date in 2018 and review of the plan of care with the ECRC, they confirmed that the plan of care was not reviewed and revised when the resident's transfer status changed.

Please note: This non-compliance was issued as a result of CI inspection which was conducted concurrently with the RQI. (581). [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) The home's policy titled: Abuse and Neglect, policy no. 004060.00, revised March 2017 indicated: Any person who had reasonable grounds to suspect that an instance of abuse or neglect had occurred or may occur should immediately report this to (1) Nurse/ At Home Leader, (2) their Coach or (3) any Coach. During after-hours or weekends and holidays this would be reported to (1) Nurse/ At home Leader who would directly call the On Call. The policy indicated it was an offense to fail to report any instance of suspected or witnessed abuse. The Executive Coach of Resident Care would notify the Ministry as per Legislation.

A) A review of the clinical record of resident #052 identified that on an identified date in 2016, staff #107 documented that resident #052, was seen demonstrating responsive behaviours towards resident #053.

The progress notes identified that on a specified date in 2016, staff #107 recorded another incident of resident #052, seen demonstrating responsive behaviours towards resident #053.

A third incident was recorded by staff #106 on a third identified date in 2016, whereby resident #052 was seen demonstrating responsive behaviours towards resident #053.

Resident #052 had a known history of a specific responsive behaviour towards co residents and staff.

On an identified date in 2018, the ECRC confirmed the recorded incidents on the identified dates in 2016, were not reported to the ECRC nor immediately to the Director and that a CI had not been completed and submitted for the incidents.

The ECRC confirmed the home's policy titled: Abuse and Neglect, policy no. 004060.00, revised March 2017, was not complied with.

Please note: This non compliance was issued as a result of CI inspection which was conducted concurrently with this RQI. (#130). [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care for resident #051 was provided to the resident as specified in the plan on December 1 and 2, 2016.

A) Resident #051 was admitted to the home in 2016 and on that day nursing staff developed the 24-Hour Care Plan, which identified care requirements.

When interviewed, resident #051's SDM said that when they came to visit the resident on a specified date in 2016, they found the resident in unsatisfactory condition. The SDM confirmed that at that time resident #051 was able to communicate with them accurately and in detail regarding what had happened and told the SDM that they were not provided assistance they required. Resident #051 told the SDM that they had woken up on the identified date in 2016 and did their own care without assistance.

The above noted information was consistent with information provided to the Director in a Critical Incident Report submitted by the ECRC in 2016, and amended several days later.

When interviewed and following a review of interview notes documented by the ECRC, PSW #114 , who would have been responsible for providing care to the resident on December 1, 2016, said the information they provided to the ECRC, when interviewed following the above noted incident was accurate. PSW #114 confirmed resident #051 had not been placed on the PSW assignment sheet and they did not provide care or supplies to the resident.

Resident #051, their SDM, investigative notes maintained by the home, a critical incident submitted to the Director and PSW staff #114 confirmed that the resident did not receive the care as specified in the plan of care on the evening shift on identified date in 2016 and the morning of a second identified date in 2016.

PLEASE NOTE: The above noted non-compliance related to resident #051 was identified while inspecting a Compliant that was conducted concurrently with the RQI.

The licensee failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of resident #051's plan of care and had convenient and immediate access to it.

A) Staff who provided direct care did not have convenient and immediate access to the 24-Hour Care Plan for resident #051.

Resident #051 was admitted to the home in 2016 and on the same day registered staff developed the 24-Hour Care Plan.

The ECRC completed an investigation into concerns expressed by resident #051's POA related to the care the resident did not receive during the evening of an identified date in 2016, and through the morning of the day after the identified date.

In a statement made and recorded during an interview with the ECRC, PSW #132 who was assigned to provide care to the resident on the identified date in 2016, indicated they did not get the 24-Hour Care Plan for resident #051.

When interviewed the ECRC confirmed that PSW #132 had told them they did not get the 24-Hour Care Plan for resident #051. The ECRC also confirmed that at the conclusion of their investigation into why resident #051 had not received the care as specified in their plan of care during the above noted period of time, they were unable to provided evidence that PSWs who were assigned to provide care to resident #051 during the day and evening on the identified date, had convenient and immediate access to the 24-Hour Care Plan for resident #051.

PLEASE NOTE: The above noted non-compliance related to resident #051 was identified while inspecting a Compliant that was conducted concurrently with the RQI.

WN #8: 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).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that the continence care and bowel management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in according with prevailing practices.

A) In accordance with 30 (1) the licensee of a long term care home shall ensure that 30

(1) 3 is complied with in respect of each of the organized programs required under section 48 of this regulation.

The ECRC was unable to provide documentation that an evaluation had been completed and confirmed in an interview that the annual program evaluation for the continence program was not completed for the year of 2017. (581). [s. 30. (1) 3.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) According to the clinical record, resident #052 had a known history of responsive behaviours towards co-residents. On an identified date in 2016, staff #107 documented that resident #052 was seen demonstrating responsive behaviours towards resident #053.

On a second identified date in 2016, staff #107 documented that resident #052 was seen demonstrating responsive behaviours towards resident #053.

On a third identified date in 2016, staff #106 documented that resident #052 was seen demonstrating responsive behaviours towards resident #053.

There was no documentation found in the clinical record of resident #053 to indicate these incidents had occurred, what immediate action had been taken, whether or not resident #053 had been assessed following the incident, what the resident's response was to the incident and whether or not the incident had been reported to the resident's SDM.

On an identified date in 2018, the ECRC confirmed that the incidents were not documented in the clinical record of resident #053 and that it was their expectation that the incident would have been documented in the plan of care of all involved parties.

Not all action taken with respect to resident #053, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Please note: This non compliance was issued as a result of CI inspection which was conducted concurrently with this RQI. (130). [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that each resident who was incontinent had an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A) A review of the critical incident report, internal investigation notes and staff interviews identified that on an identified date in 2018, resident #020 asked PSW #116 for assistance with an activity of daily living (ADL). PSW #116 identified that their partner, PSW #115, was in another area of the home and would assist them as soon as they could. When PSWs #116 and #115 arrived to provide assistance, PSW #115 identified to the resident that they were going to provide care in a different manner that what had been requested by the resident. The resident stated they would prefer assistance be provided in a different manner that what was being proposed by staff. PSW #115 responded that they would provide different assistance. The home's internal investigation notes included an interview with PSW #115 where they identified that they provided assistance to the resident in a manner that they felt was safer for the resident.

A review of the clinical record for resident #020 identified an assessment completed on an identified date in 2017, which identified the resident's assessed needs specifically related to an ADL. The plan of care identified specifically what assistance was to be provided to the resident with the specific ADL.

In an interview with the ECRC on an identified date in 2018, they identified specifically assistance was to be provided to the resident and at which time it was to be provided.

On an identified date in 2018, the ECRC acknowledged that the home did not ensure that resident #020's individualized plan, specifically related to an ADL, which was based on their admission assessment, was not implemented when PSWs #115 and #116 provided assistance to the resident on an identified date in 2018.

Please note: This non compliance was issued as a result of critical incident inspection which was conducted concurrently with the RQI. (683). [s. 51. (2) (b)]

WN #10: 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 :

The licensee failed to ensure that they sought the advice of Family Council in developing and carrying out the satisfaction survey.

The President of Family Council was interviewed on an identified date in 2018, as part of the mandatory home tasks for the RQI. In the interview, the President of Family Council identified that they did not recall ever reviewing the questions for the satisfaction survey. In separate interviews with the Life Transition Coach, who was the assistant to the Family Council, and the ECRC identified that in the past, the home sought the advice of the Family Council in developing and carrying out the satisfaction survey, but indicated that the home had used the same survey for the past few years. On an identified date in 2018, the ECRC confirmed that the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey. (683). [s. 85. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of an incident in the home no later than one business day after the occurrence of the incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A) A Critical Incident was reported by the home on an identified date in 2017 related to a fall sustained by resident #011. On a later date in 2017, the resident was transferred to hospital and was diagnosed with a specific injury which required treatment
.
During an interview the ECRC acknowledged that the CI was submitted to the Director on an identified date in 2017 and said that the Director should have been notified on a specific date in 2017.

Please note: This non-compliance was issued as a result of the CI inspection which was conducted concurrently with this RQI. (581).

B) The home submitted a CI on an identified date in 2017, related to a fall sustained by resident #031 on an identified date in 2017. The resident was transferred to hospital on an identified date in 2017 and diagnosed with a specific injury which required treatment.

During an interview the ECRC acknowledged that the CI was submitted on the identified date in 2017 and said the Director should have been notified on an earlier date in 2017. It was confirmed that CI reports were not reported within the specified time-frames.

Please note: This non compliance was issued as a result of the CI inspection which was conducted concurrently with this RQI. (581). [s. 107. (3)]

WN #12: 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 :

The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 29 of the Act and what changes and improvements were required to minimize restraining and to ensure that any restraining that was necessary was done in accordance with the Act and this Regulation.

The ECRC was unable to provide documentation that an evaluation had been completed and confirmed in an interview in 2018, that an evaluation of the Minimizing Restraints program was not completed for the year of 2017. (581). [s. 113. (b)]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 19th day of November, 2018

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

Original report signed by the inspector.