Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office

119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
Facsimile: 905-546-8255

Bureau régional de services de Hamilton

119, rue King Ouest, 11e étage
Hamilton ON L8P 4Y7
Téléphone: 1-800-461-7137
Télécopieur: 905-546-8255

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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/GeNR/RCe d'inspection**
May 15-18, 2012 and May 21-22, 2012 (onsite)	2012_ 2775_199_0002	Other - Data Quality Inspection (Restorative Care and Therapies)

Licensee/Titulaire
Shalom Village Nursing Home
70 Macklin Street, North
Hamilton, Ontario
L8S 3S1
905-529-1613

Long-Term Care Home/Foyer de soins de longue durée
Shalom Village Nursing Home,
70 Macklin Street, North,
Hamilton, Ontario,
L8S 3S1
905-529-1613

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

Nancy Rawlings (199) Lead
Patricia Ordowich (198)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Data Quality inspection related to restorative care and therapies.
During the course of the inspection, the inspectors spoke with: Administrator, Director of Nursing and Personal Care (DONPC), Director of Nursing and Personal Care (DONPC)/Restorative Care Coordinator, RAI Coordinator (RAI-C)/Restorative Care Coordinator, Physiotherapist (PT), Physiotherapy Assistant (PTA), Restorative Care Aid/Personal Support Worker, Clinical Director.

During the course of the inspection, the inspectors reviewed: resident health records for 10 residents in the home for the quarters from July 1, 2010 to March 31, 2011 and the most recent completed RAI-MDS 2.0 (January 1, 2012 to March 31, 2012) that was submitted to the Canadian Institute for Health Information (CIHI) for those residents who still lived in the home as well as the home policies and procedures for restorative care including therapies.

The following Inspection Protocol was used in part or in whole during this inspection: Restorative Care and Therapy.

☒ Findings of Non-Compliance were found during this inspection.

NON- COMPLIANCE / (Non-respectés)

Definitions /Définitions that may have been used in the report.

VPC = Voluntary Plan of Correction
WN = Written Notification

AC = before meals
ARD = assessment reference date
AROM = active range of motion
CIHI = Canadian Institute for Health Information
DONPC = Director of Nursing and Personal Care
RAI-MDS 2.0 = Resident Assessment Instrument Minimum Data Set Version 2.0
NR/RC = Nursing Rehabilitation/Restorative Care
PC = after meal
PROM = passive range of motion
PT = Physiotherapy
QHS = every evening at bedtime
RAI-C = RAI Co-ordinator
RAPs = Resident Assessment Protocols

Q2 = July 1 to September 30, 2010
Q3 = October 1 to December 31, 2010
Q4 = January 1 to March 31, 2011
Most recent quarter inspected = January 1, 2012 to March 31, 2012

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *Long Term Care Homes Act (LTCHA), 2007*, c. 8, s. 101.

(1) A license is subject to the conditions, if any, that are provided for in the regulations. 2007, c. 8, s. 101.

(2) The Director may make a licence subject to conditions other than those provided for in the regulations,

(a) at the time a license is issued, with or without the consent of the licensee; or

(b) at the time a license is reissued under section 105, with or without the consent of the new licensee. 2007, c. 8, s. 101 (2).

(3) It is a condition of every licence that the licensee shall comply with this Act, the *Local Health System Integration Act, 2006*, the *Commitment to the Future of Medicare Act, 2004*, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

(4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101 (4);

Findings:

1. The Long-Term Care Homes Service Accountability Agreement (L-SAA) is an agreement entered into between the local health integration network and the Licensee, Shalom Village Nursing Home, under the *Local Health System Integration Act, 2006*. Compliance with the L-SAA is, therefore, a condition of the license issued to Shalom Village Nursing Home for the Shalom Village Nursing Home long-term care home.
2. The Licensee has failed to comply with the following provisions of the L-SAA:

Article 3.1

(a) The HSP will provide the Services in accordance with:
- (i) this Agreement;
- (ii) Applicable Law; and
- (iii) Applicable Policy.

Article 8.1

(a) The LHIN's ability to enable its local health system to provide appropriate, co-ordinated, effective and efficient health services as contemplated by LHSIA, is heavily dependent on the timely collection and analysis of accurate information. The Health Service Provider (HSP) acknowledges that the timely provision of accurate information related to the HSP is under the HSP's control;

Article 8.1(b): The HSP [Health Service Provider]

(iv) will ensure that all information is complete, accurate, provided in a timely manner and in a form satisfactory to the LHIN [Local Health Integration Network];

Article 8.1 (c): The HSP will:

(i) conduct quarterly assessments of Residents, and all other assessments of Residents required under the Act, using a standardized Resident Assessment Instrument - Minimum Data Set (RAI-MDS 2.0) 2.0 tool in accordance with the RAI-MDS 2.0 Practice Requirements included in Schedule F and will submit RAI-MDS 2.0 assessment data to the Canadian Institute for Health Information (CIHI) in an electronic format at least quarterly in accordance with the submission guidelines set out by CIHI; and

(ii) have systems in place to regularly monitor and evaluate the RAI-MDS 2.0 data quality and accuracy;

3. The RAI-MDS 2.0 LTC Homes – Practice Requirements are included in Schedule F of the L-SAA and fall

within the definition of "Applicable Policy" under the L-SAA.

4. The RAI-MDS 2.0 Agreement between the Minister of Health and Long-Term Care and the Licensee, Shalom Village Nursing Home, is an agreement under the *Long-Term Care Homes Act, 2007* for the provision of funding related to the implementation of RAI-MDS 2.0 assessment tool in long-term care homes. Compliance with the RAI-MDS 2.0 Agreement is, therefore, a condition of the license issued to Shalom Village Nursing Home for the Shalom Village Nursing Home long-term care home.
5. The documents listed in Schedules A to E of the RAI-MDS 2.0 Agreement between the Licensee, Shalom Village Nursing Home and the Ministry of Health and Long-Term Care fall within the definition of "Applicable Policy" in the L-SAA. These documents include, but are not limited to, the Sustainability Project Description, the Implementation Information Package together with the Training Module Overview, and the RAI Coordinator Role Description.
6. The level-of-care per diem funding in the Nursing and Personal Care (NPC) envelope paid by the local health integration network to the Licensee pursuant to the L-SAA is adjusted based on resident acuity. The higher the acuity, the greater the funding. The amount of funding in the NPC envelope is calculated using a formula set out in the LTCH Level-Of-Care Per Diem Funding Policy (a policy listed in Schedule F of the L-SAA) and resident acuity is determined using the RAI-MDS 2.0 information submitted by the Licensee to CIHI.
7. The incompleteness and inaccuracy of the RAI-MDS 2.0 data is evidenced by the following:
   (a) The RAI-MDS 2.0 coding was not supported by the home's documentation, including the residents' plans of care and the RAPs documentation. There were multiple inconsistencies between what was coded on the RAI-MDS 2.0 and the progress notes found in the residents' plans of care.
8. The following are specific examples of incomplete and/or inaccurate RAI-MDS 2.0 coding and non-compliance with the L-SAA and/or the RAI-MDS 2.0 LTC Homes – Practice Requirements and/or the Implementation Information Package and/or the RAI Coordinator Role Description and/or the RAI-MDS 2.0 Agreement. The RAI-MDS 2.0 Practice Requirements mandates the use of the RAI-MDS 2.0 Manual, which states that a rehabilitation or restorative practice must meet specific criteria including that measureable objectives and interventions must be documented in the care plan and in the clinical record.

   a. For resident 001:
      - There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded for NR/RC for scheduled toileting plan and also that the resident was totally incontinent of bladder. The plan of care documented routine toileting (i.e. check for wetness ac, pc meals and QHS. Check for wetness on rounds during the night). The scheduled toileting plan is a plan whereby staff members at scheduled times each day either take the resident to the toilet room or give the resident a urinal, or remind the resident to go to the toilet. It does not include the provision of incontinence care or the changing of pads and/or linens on a regular schedule. Therefore the scheduled toileting plan did not meet the RAI-MDS 2.0 definition but rather routine toileting as the purpose of the scheduled toileting plan is that the resident will achieve or maintain a level of continence.

   b. For resident 002:
      - There was inconsistency in what was coded on the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0) and the documentation in the plan of care. It was documented on the RAI-MDS 2.0 that the resident received Nursing Rehabilitation/Restorative Care (NR/RC) activities for eating or swallowing. The RAI-MDS 2.0 was also coded that the resident received assistance of 1 staff for eating and was totally dependent during the entire observation period. The resident was coded as being totally dependent for the NR/RC activity eating or swallowing indicating that the resident did not participate during the observation period. It was unclear according to documentation if the resident received the NR/RC activity of eating or swallowing.

c. For resident 003:

- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded for 7 days of NR/RC walking activity. However, the PSW Documentation record indicated that the resident received 4 days of NR/RC walking. The RAI-MDS 2.0 coding did not match the actual care provided. It was unclear according to the documentation if the resident received the NR/RC activity of walking.
- There was discrepancy between the documentation on the RAI-MDS and the PT treatment record. The PT treatment record documented that PT was provided for 2 days for a total of 30 minutes however the RAI-MDS 2.0 was documented that PT was provided for 3 days for a total of 45 minutes during the observation period.

d. For resident 004:

- There was a discrepancy between the documentation on the RAI-MDS and the PT treatment record. The PT treatment record documented that PT was provided for 2 days for a total of 30 minutes however the RAI-MDS 2.0 was documented that PT was provided for 3 days for a total of 45 minutes during the observation period. The PT treatment record indicated that the resident was sick for one day during the observation period so therapy was not provided.
- There was a discrepancy between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded that the resident was on a NR/RC transfer activity for 7 days during the observation period but the NR/RC activity log indicated that the resident only participated for 3 days.

e. For resident 005

- There was inconsistency in what was coded on the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0) and the documentation in the plan of care. It was documented on the RAI-MDS 2.0 that the resident received Nursing Rehabilitation/Restorative Care (NR/RC) activities for eating or swallowing. The RAI-MDS 2.0 was coded that the resident was totally dependent during the entire observation period for eating. The resident was coded as being totally dependent for the NR/RC activities indicating that the resident did not participate during the observation period. The plan of care did not give direction for swallowing interventions and indicated not to rush resident during meal times.
- There was a discrepancy in what was coded on the RAI–MDS 2.0 and the documentation in the plan of care for resident 005. The resident was coded on the RAI-MDS 2.0 as receiving 3 days of PT for a total of 45 minutes; however the PT treatment record documentation did not have the year indicated therefore it was unclear according to documentation if the resident had received the therapy during the observation period.

f. For resident 006

- There was inconsistency in what was coded on the RAI–MDS 2.0 and the documentation in the plan of care. The RAI-MDS 2.0 was coded that the resident received 7 days of the NR/RC activity for eating however the plan of care said to provide total feeding and the resident was coded as being totally dependent for eating indicating that the resident did not participate during the observation period. Therefore it was unclear according to documentation if the resident received the NR/RC activity coded on the RAI-MDS 2.0.

g. For resident 007:

- The resident was coded on the RAI-MDS 2.0 as receiving 7 days of NR/RC transfer activity during the observation period. However there was no documentation in the plan of care regarding the provision of care for the NR/RC activity. Therefore it was unclear according to documentation if the resident received the NR/RC activity coded on the RAI-MDS 2.0.

- There was inconsistency in what was coded on the RAI-MDS 2.0 and the documentation in the health record. There were no measureable objectives or interventions documented in the care plan and in the clinical record for the PT therapy that was coded. Therefore it was unclear according to documentation what PT was received during the observation period.

h. For resident 008:

- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded for 7 days of NR/RC communication and eating or swallowing activities. However, the PSW Documentation record indicated that the resident received 4 days of NR/RC communication and eating or swallowing. The RAI-MDS 2.0 coding did not match the actual care provided. It was unclear according to the documentation if the resident received the NR/RC activities for communication and eating or swallowing.

i. For resident 009:

- The resident was coded on the RAI-MDS 2.0 as receiving 3 days and 45 minutes of PT during the observation period. However there was no plan of care or PT treatment records provided or found on residents' health record. Therefore it was unclear according to documentation if the resident received the PT coded on the RAI-MDS 2.0.
- There were discrepancies between the coding of the RAI-MDS 2.0 and the documentation. The RAI-MDS 2.0 was coded for 7 days of NR/RC eating. However, the PSW Documentation record indicated that the resident received 6 days of NR/RC eating. The RAI-MDS 2.0 coding did not match the actual care provided. It was unclear according to the documentation if the resident received the NR/RC activities for eating.

j. For Resident 010:

- There were discrepancies between the coding of the RAI-MDS 2.0 and the plan of care. The RAI-MDS 2.0 was coded for NR/RC for scheduled toileting plan and also that the resident was totally incontinent of bladder. The plan of care documented routine toileting (i.e. team will toilet resident ac, pc meals and QHS. Resident will notify team of additional toileting needs as required). The scheduled toileting plan is a plan whereby staff members at scheduled times each day either take the resident to the toilet room or give the resident a urinal, or remind the resident to go to the toilet. It does not include the provision of incontinence care or the changing of pads and/or linens on a regular schedule. Therefore the scheduled toileting plan did not meet the RAI-MDS 2.0 definition but rather routine toileting as the purpose of the scheduled toileting plan is that resident will achieve or maintain a level of continence.

Inspector ID #:	199, 198

Additional Required Actions:

Voluntary Plan of Correction (VPC) - Pursuant to the Long Term Care Homes Act (LTCHA), 2007, c.8, s.101, the licensee is hereby requested to prepare a written plan of corrective action for achieving compliance with the RAI-MDS 2.0 Long Term Care Homes Practice Requirements, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. PAT ORBOWICH
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). AUGUST 9, 2012