Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 13, 2018	2018_520622_0010	009076-18	Resident Quality Inspection

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

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

HEATH HEFFERNAN (622), AMBER LAM (541), JESSICA PATTISON (197)

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 9, 10, 11, 14, 15, 16, 17, 18, 22, 23, 24, 2018

The following intakes were included in this inspection:

Critical Incident intake:
Log #003696-18 (CIS #0962-000002-18) - resident fall.

Complaint intakes:
Log #007258-18 related to sufficient staffing.
Log #024947-17 related to sufficient staffing.
Log #008798-18 related to nutrition and hydration specific to weights and a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), the Director of Resident Care (DRC), the Manager of Resident Services, the Environmental Coordinator, the Maintenance Coordinator, the Recreation Coordinator, the Clinical Care Lead, the Registered Dietician (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA), an Activity Aide, Physiotherapy Assistant, Scheduling staff, a Dietary Aide, the Family Council Representative, the Resident Council President, family and the residents.

The inspectors also conducted a tour of the home, observed the administration of medication, reviewed medication incident documentation, observed meal services, reviewed policies related to monitoring of resident weights, weight monitoring and evaluation, reviewed call bell audit procedure, the staffing plan, the family council meeting minutes, the Residents' Council meeting minutes and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 VPC(s)
3 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The home failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to the area by residents, and that the doors were kept closed and locked when they were not being supervised by staff.

Resident #030 was identified as being a high risk of falls according to the most recent Resident Assessment Protocol (RAP) completed and has moderate cognitive impairment. As per the current care plan, resident #030 required extensive assistance of 1 staff to walk in the corridor while using a specified assistive device.

Resident #030 resided on a specified resident home area of the home. The specified resident home area had a door which was identified as a non-residential area. The non-residential area contained items of potential risk to residents. Once inside the non-residential area, there was access to the servery and the resident dining room. The non-residential area could also be accessed from a door in the resident dining room. Inspector interviewed PSW #116, PSW #115, RPN #120 and RN #121 regarding the non-residential area doors and all staff indicated the doors were to be kept locked to prevent resident access.

On a specified date and time, resident #030 fell in the non-residential area. The progress note entered post-fall on the specified date indicated it was unknown how resident #030 got into the non-residential area. Resident #030 did not appear to have any injuries at the time of the fall according to the progress note.

Inspector interviewed RPN #120 who was completing the specified shift when the resident was found. RPN #120 was unsure how the resident gained access to the non-residential area but stated that sometimes at shift change the door to the non-residential area was left open.

PSW #115 was interviewed by Inspector #541 and indicated they were coming for the specified shift on the specified date. PSW #115 stated the staff were sitting in the dining room about to start shift report when a dietary staff member came to them and stated that resident #030 was on the floor in the non-residential area. PSW #115 stated the light was off in the non-residential area and when they entered resident #030 was on the floor. PSW #115 further stated the non-residential area door on the specified resident home area was locked, therefore resident #030 gained access to the non-residential area from the door in the dining room. PSW #115 indicated the dining room door was normally kept locked outside of meal hours, as is the non-residential area door but on the specified date, both the non-residential area and dining room doors were propped open. PSW

#115 stated that sometimes the staff on a specified shift would keep the non-residential area door open if they were to get a resident a drink. Resident #030 was unable to recall how long they had been in the non-residential area when asked by the staff who found them. Resident #030 did not sustain any injury as a result.

The home failed to ensure that the door to the non-residential area on a specified resident home area was kept closed and locked when it was not being supervised by staff and as a result resident #030 gained access to the non-residential area and sustained a fall.

The severity of this issue was determined to be a level 3 as there was actual risk to resident #030 who gained access to the unsupervised non-residential area and sustained a fall. The scope of the issue was a level 1 as only one of three falls reviewed were due to an unlocked door leading to a non-residential area. The home has a level 4 history as they have on-going non-compliance with this section of the LTCHA that includes:
- Voluntary plan of correction (VPC) issued October 23, 2017 (2017_505103_0046) [s. 9. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy that the policy was complied with.

In accordance with O. Reg 79/10, s. 68 (2) (a) the licensee is required to ensure that the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the licensee’s policy Monitoring of Resident Weights LTC-RCM-G-20.80 which is part of the licensee’s nutrition care and dietary service program.

Resident #024 was noted to have a significant weight loss between two specified months. Upon review of resident #024’s monthly weights it was noted that resident #024 had significant weight changes over a 6 month period.
A progress note entered for resident #024 on a specified date by RN #106 indicated resident #024’s weights fluctuated over an 8 month period and no re-weighs were completed therefore unable to determine accuracy of the weights.

Resident #017’s monthly weights were reviewed which indicated significant weight changes over a seven month period.
A progress note entered for resident #017 on a specified date by RN #106 indicated resident #017’s weights fluctuated over seven months and no re-weighs were completed therefore unable to determine the accuracy of the weights.

Resident #005 monthly weights were reviewed which indicated significant weight changes over a four month period.
No documentation was entered to indicate resident #005 was re-weighed on the dates noted above.

The following residents were also noted to be missing monthly weights:
Resident #001: a specified month weight missing
Resident #005: a specified month weight missing
Resident #017: Missing weights for four specified months.

PSW’s #128, 130 and 131 were interviewed regarding the process for obtaining resident’s monthly weights and all three PSWs indicated monthly weights are done

during resident's bath and the weight is then written on the paper weight sheet kept in the tub room. When asked about how re-weighs are completed, PSW #128 stated if a re-weigh is needed, it is requested by the registered staff and the PSW are informed of this when they receive their shift assignment.

Inspector #541 obtained the weight sheet kept in the tub room and noted the previous months weights were not on the sheet. PSW #131 was asked how they would know to complete a re-weigh if the previous month's weight was not provided and the PSW stated they would not know to complete a re-weigh until asked by a registered staff member.

Inspector spoke with RPN #129 who indicated they sometimes enter resident's monthly weights. When asked how a re-weigh is documented they stated they would note this on the paper weight sheet but further stated the paper weight sheets are discarded once the monthly weights are entered.

The home's Registered Dietitian (RD) #132 was interviewed and indicated missing monthly weights and obtaining re-weighs have been ongoing issues. RD #132 stated that completing quarterly assessments in the Minimum Data Set (MDS) has been delayed due to waiting for resident weights.

Inspector requested the home's policy for resident weights and was provided with policy LTC-RCM-G-20.80 titled Monitoring of Resident Weights and policy DS-III-025 titled Weight Monitoring and Evaluation.
Policy LTC-RCM-G-20.80 states:
The Director of Care or designate will:
- Ensure a documentation tool is used which includes the resident's previous month's weights for PSW's to record monthly weights.
The RN/RPN will:
- Record monthly weights or re-weights from the PSW documentation tool into the weights and vitals system of the electronic documentation system by the 10th of every month.
- Request the PSW to reweigh the resident if there is an unanticipated weight change (loss or gain) or a two kilogram difference in the resident's previous month.

The PSW will:
- Immediately re-weigh any resident with a weight variance (from previous month) of 2 kg.

The licensee failed to ensure the policy related to the monitoring of resident weights was complied with.

The severity of this issue was determined to be a level 2 as there is a potential for actual harm to the residents. The scope of the issue is a level 3 as it relates to four of four residents reviewed. The home has a level 3 compliance history as they have non-compliance with O. Reg 79/10 s. 8(1) as it relates to the nutrition and hydration program that includes:
- Voluntary plan of correction (VPC) issued October 16, 2017 (2017_505103_0046) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents’ personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures developed to ensure the resident-staff communication and response system is kept in a good state of repair, were implemented.

During stage 1 of the Resident Quality Inspection, inspectors found the following:

Resident #002 - bathroom call bell would not activate
Inspector #622 spoke with a member of the maintenance staff who also tried to activate the call bell but could not.

Resident #032 - the call bell cord would not activate
Inspector #622 spoke with a PSW who stated they would find another cord for the call bell.

Resident #037 - bathroom call bell would not activate
Inspector #197 informed a PSW who confirmed the call bell would not activate.

Resident #026 - bathroom call bell would not activate
Inspector #197 informed a PSW who confirmed the bell did not work. The PSW indicated they would notify maintenance to have it fixed.

The Environmental Coordinator indicated that the home does have a process to audit the resident-staff communication and response system and provided a blank copy of the audit sheets, as well as the written process. They indicated that auditing the system is their responsibility and that it is to be done monthly. The Environmental Coordinator indicated to the inspector that monthly audits had not been completed yet for 2018.

The severity of this issue was determined to be a level 3 as there was potential for actual harm to the residents whose resident-staff communication and response system failed to function. The scope of the issue is a level 1, ten percent of the resident population inspected were affected. The home has a level 2 history as they have 1 or more unrelated NC in last 36 months. [s. 90. (2) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents’ assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's staffing plan includes a back-up plan for nursing and personal care staffing and that the plan gets evaluated and updated at least annually.

On May 17, 2018, the Administrator was asked to provide a copy of the home's staffing plan. At that time the Administrator was unable to provide the staffing plan as they had started working in the home during a specified month and was unsure where the past Administrator kept the plan.

On May 22, 2018, the Administrator provided a copy of all of the documents they could find related to staffing in the home and indicated that they would consider this the home's staffing plan. The documents provided did not include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) and there was no evidence that it had been evaluated and updated at least annually. [s. 31. (3)]

2. The licensee has failed to ensure that there is a written record of each annual evaluation of the staffing plan.

The Administrator and Director of Care for the home were asked to provide a copy of the home's staffing plan, as well as a written record of the last annual evaluation. Both staff members began working in the home during a specified month and after looking through the homes records, were not able to provide a copy of the written evaluation. The Administrator indicated that it did not appear that an evaluation of the staffing plan had been done in 2017. [s. 31. (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 the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices

and

to ensure a written record is kept relating to each evaluation 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The following finding is related to logs 024947-17 and 007258-18:

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

On a specified date, the assignment book for a specified floor was reviewed, as well as Point of Care (POC) in Mede-care.

Resident #036's scheduled bath days were on two specified days of the week. There was no documented bath for the resident on two specified dates during a one month period. The assignment sheet for one of the specified dates indicated no baths were done as the home was short staff on two shifts.

Resident #039's scheduled bath days were on two specified days of the week. There was no documented bath for the resident on four specified dates during a one month period. The assignment sheets for two of the specified dates indicated no baths were done as the home was short staff on the specified shift.

Resident #042's scheduled bath days were on two specified days of the week. There was no documented bath for the resident on one of the specified dates.

Resident #045's scheduled bath days were on two specified days of the week. There was no documented bath for the resident on four specified dates during a one month period. The assignment sheet for one of the specified dates indicated baths were not done due to being short two staff on the specified shift.

Resident #046's scheduled bath days were on two specified days of the week. There was no documented bath for the resident on two specified dates during a one month period. The assignment sheets for the two specified dates both state that no baths were done due to short staffing on two specified shifts.
For all of the residents listed above, there was no documentation to suggest that the missed baths were made up at a later time.

HCA #133 stated in an interview that baths do not get done when the home is short-staffed.

The Administrator stated in an interview that they are aware baths are being missed and plans to address this in the home's upcoming review of staffing. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: 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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee seeks the advice of the Residents' and Family Councils in developing and carrying out the satisfaction survey, and in acting on its results.

On a specified date, a member of the Family Council was interviewed regarding the satisfaction survey. This member indicated that they did not think the home had completed a satisfaction survey in the last year and if they did, the Family Council had not been involved in the development and/or acting on its results.

The minutes for the Family Council meetings were reviewed for a three month period and there was no evidence that the satisfaction survey was ever discussed.

Activity Aide #119 was interviewed and stated that the home had completed a satisfaction survey in 2017 and that they had helped some residents fill it out. They further stated that they did not think that the survey was brought to either the Family or Residents' Council to seek their advice.   Activity Aide #119 stated that the survey comes from Diversicare. [s. 85. (3)]

2. 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.

Resident #042 is the home's Resident Council president and was interviewed by Inspector #541 on a specified date. Resident #042 was unable to recall a discussion at a council meeting regarding the home's resident satisfaction survey. Staff member #122 is the assistant to the Resident Council and was interviewed by inspector #541 on a specified date. Staff member #122 indicated the advice of the Resident's Council was not sought in developing and carrying out the satisfaction survey. The home's Administrator confirmed on a specified date that the council advice was not sought in developing and carrying out the satisfaction survey. [s. 85. (3)]

3. The licensee has failed to ensure that the results of the satisfaction survey are made available to the Residents' and Family Councils in order to seek the advice of the Councils about the survey.

On a specified date, a member of the Family Council was interviewed and indicated that they were not aware of a satisfaction survey taking place in the home and if it had, the results of this survey had not been shared with the Family Council.

The Family Council meeting minutes were reviewed for a three month period and there was no evidence that the home had made the results of the satisfaction survey available to the Council.

Activity Aide #119 indicated to the inspector that they did not think the results of the satisfaction survey for 2017 were made available to either the Family or the Residents' Council. [s. 85. (4) (a)]

4. The licensee has failed to ensure that the licensee document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

Resident #042 is the home's Resident Council president and was interviewed by Inspector #541 on a specified date. Resident #042 was unable to recall a discussion at a council meeting regarding the results of the home's resident satisfaction survey. Staff member #122 is the assistant to the Resident Council and was interviewed by inspector #541 on a specified date. Staff member #122 indicated the results of the satisfaction survey was not discussed with the Resident's Council. The home's Administrator confirmed on a specified date that the results of the resident's satisfaction survey was not discussed with the council. [s. 85. (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 the licensee seeks 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

and

to ensure that the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure drugs were administered to residents #044, #012 and #015 in accordance with the directions for use specified by the prescriber.

On a specified date, inspector #622 reviewed the home's medication incidents for a three month period. Three medication incidents were inspected as follows:

Incident #1:

On a specified date, inspector #622 reviewed resident #044's physician's orders which indicated that the resident had been prescribed a specified medication to be administered at a specified time.

On a specified date, inspector #622 reviewed the Medication Incident/Near Miss Report which indicated on a specified date, RPN #103 noted that resident #044 missed a dose of a specified medication at specified time. The medication was signed that it had been administered on the electronic medication administration record (eMar), however the specified medication remained in the medication card. There were no untoward effects to resident #044 as a result of the error.

Incident #2:

On a specified date, inspector #622 reviewed resident #012's physician's orders which indicated resident #012 was prescribed a specified medication to be applied at a specified time and removed at a specified time daily.

On a specified date, inspector #622 reviewed the Medication Incident/Near Miss Report which indicated on a specified date during the a specified shift when removing resident #012's specified medication, RPN #106 noted resident #012 had two applications of the specified medication, one dated on the specified date and the other a day prior. The

specified medication was not removed on a specified date and time according to the physician's direction. There were no untoward effects to resident #012 as a result of the error.

Incident #3:

On a specified date, inspector #622 reviewed resident #015's physician's orders which indicated resident #015 was prescribed a specified medication twice daily.

On a specified date, inspector #622 reviewed the Medication Incident/Near Miss Report which indicated on a specified date, resident #015 missed their dose of specified medication at at a specified time. The medication was signed that it had been administered on the eMar however remained in the medication lock box, not administered. There were no untoward effects to resident #015 as a result of the error.

On a specified date and time, inspector #622 interviewed the Director of Resident Care (DRC) #105 who reviewed the three medication incidents dated three specified dates. DRC #105 stated the medications were not administered to residents #015, #044 and #012 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 13th day of June, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATH HEFFERNAN (622), AMBER LAM (541), JESSICA PATTISON (197)
Inspection No. / No de l'inspection :	2018_520622_0010
Log No. / No de registre :	009076-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 13, 2018
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Perth Community Care Centre 101 Christie Lake Road, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Cummins

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To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10. s. 9(1).

Specifically the licensee must ensure:
- that both doors leading to the pantry on the second floor are kept closed and locked to prevent resident access when the area is unsupervised.

Grounds / Motifs :

1. 1. The home failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to the area by residents, and that the doors were kept closed and locked when they were not being supervised by staff.

Resident #030 was identified as being a high risk of falls according to the most recent Resident Assessment Protocol (RAP) completed and has moderate cognitive impairment. As per the current care plan, resident #030 required extensive assistance of 1 staff to walk in the corridor while using a specified assistive device.

Resident #030 resided on a specified resident home area of the home. The specified resident home area had a door which was identified as a non-residential area. The non-residential area contained items of potential risk to residents. Once inside the non-residential area, there was access to the servery and the resident dining room. The non-residential area could also be accessed from a door in the resident dining room. Inspector interviewed PSW #116, PSW #115, RPN #120 and RN #121 regarding the non-residential area doors and all staff indicated the doors were to be kept locked to prevent resident access.

On a specified date and time, resident #030 fell in the non-residential area. The progress note entered post-fall on the specified date indicated it was unknown how resident #030 got into the non-residential area. Resident #030 did not appear to have any injuries at the time of the fall according to the progress note.

Inspector interviewed RPN #120 who was completing the specified shift when the resident was found. RPN #120 was unsure how the resident gained access to the non-residential area but stated that sometimes at shift change the door to the non-residential area was left open.

PSW #115 was interviewed by Inspector #541 and indicated they were coming for the specified shift on the specified date. PSW #115 stated the staff were

sitting in the dining room about to start shift report when a dietary staff member came to them and stated that resident #030 was on the floor in the non-residential area. PSW #115 stated the light was off in the non-residential area and when they entered resident #030 was on the floor. PSW #115 further stated the non-residential area door on the specified resident home area was locked, therefore resident #030 gained access to the non-residential area from the door in the dining room. PSW #115 indicated the dining room door was normally kept locked outside of meal hours, as is the non-residential area door but on the specified date, both the non-residential area and dining room doors were propped open. PSW #115 stated that sometimes the staff on a specified shift would keep the non-residential area door open if they were to get a resident a drink. Resident #030 was unable to recall how long they had been in the non-residential area when asked by the staff who found them. Resident #030 did not sustain any injury as a result.

The home failed to ensure that the door to the non-residential area on a specified resident home area was kept closed and locked when it was not being supervised by staff and as a result resident #030 gained access to the non-residential area and sustained a fall.

The severity of this issue was determined to be a level 3 as there was actual risk to resident #030 who gained access to the unsupervised non-residential area and sustained a fall. The scope of the issue was a level 1 as only one of three falls reviewed were due to an unlocked door leading to a non-residential area. The home has a level 4 history as they have on-going non-compliance with this section of the LTCHA that includes:
- Voluntary plan of correction (VPC) issued October 23, 2017 (2017_505103_0046) [s. 9. (1) 2.] (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 22, 2018

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 8(1)

Specifically, the licensee must:

- Ensure all staff completing resident weights have access to a documentation tool that includes the previous month's weights.
- Immediately re-weigh any resident with a weight variance (from previous month) of 2 kg and enter this information into the electronic documentation system by the 10th of every month.
- Enter monthly weights for residents #001, 005 and 017 and all other residents into the electronic documentation system by the 10th of every month.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy that the policy was complied with.

In accordance with O. Reg 79/10, s. 68 (2) (a) the licensee is required to ensure that the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the licensee's policy Monitoring of Resident

Weights LTC-RCM-G-20.80 which is part of the licensee's nutrition care and dietary service program.

Resident #024 was noted to have a significant weight loss between two specified months. Upon review of resident #024's monthly weights it was noted that resident #024 had significant weight changes over a 6 month period.
A progress note entered for resident #024 on a specified date by RN #106 indicated resident #024's weights fluctuated over an 8 month period and no re-weighs were completed therefore unable to determine accuracy of the weights.

Resident #017's monthly weights were reviewed which indicated significant weight changes over a seven month period.
A progress note entered for resident #017 on a specified date by RN #106 indicated resident #017's weights fluctuated over seven months and no re-weighs were completed therefore unable to determine the accuracy of the weights.

Resident #005 monthly weights were reviewed which indicated significant weight changes over a four month period.
No documentation was entered to indicate resident #005 was re-weighed on the dates noted above.

The following residents were also noted to be missing monthly weights:
Resident #001: a specified month weight missing
Resident #005: a specified month weight missing
Resident #017: Missing weights for four specified months.

PSW's #128, 130 and 131 were interviewed regarding the process for obtaining resident's monthly weights and all three PSWs indicated monthly weights are done during resident's bath and the weight is then written on the paper weight sheet kept in the tub room. When asked about how re-weighs are completed, PSW #128 stated if a re-weigh is needed, it is requested by the registered staff and the PSW are informed of this when they receive their shift assignment.

Inspector #541 obtained the weight sheet kept in the tub room and noted the previous months weights were not on the sheet. PSW #131 was asked how they would know to complete a re-weigh if the previous month's weight was not provided and the PSW stated they would not know to complete a re-weigh until asked by a registered staff member.

Inspector spoke with RPN #129 who indicated they sometimes enter resident's monthly weights. When asked how a re-weigh is documented they stated they would note this on the paper weight sheet but further stated the paper weight sheets are discarded once the monthly weights are entered.

The home's Registered Dietitian (RD) #132 was interviewed and indicated missing monthly weights and obtaining re-weighs have been ongoing issues. RD #132 stated that completing quarterly assessments in the Minimum Data Set (MDS) has been delayed due to waiting for resident weights.

Inspector requested the home's policy for resident weights and was provided with policy LTC-RCM-G-20.80 titled Monitoring of Resident Weights and policy DS-III-025 titled Weight Monitoring and Evaluation.
Policy LTC-RCM-G-20.80 states:
The Director of Care or designate will:
- Ensure a documentation tool is used which includes the resident's previous month's weights for PSW's to record monthly weights.
The RN/RPN will:
- Record monthly weights or re-weights from the PSW documentation tool into the weights and vitals system of the electronic documentation system by the 10th of every month.
- Request the PSW to reweigh the resident if there is an unanticipated weight change (loss or gain) or a two kilogram difference in the resident's previous month.

The PSW will:
- Immediately re-weigh any resident with a weight variance (from previous month) of 2 kg.

The licensee failed to ensure the policy related to the monitoring of resident weights was complied with.

The severity of this issue was determined to be a level 2 as there is a potential for actual harm to the residents. The scope of the issue is a level 3 as it relates to four of four residents reviewed. The home has a level 3 compliance history as they have non-compliance with O. Reg 79/10 s. 8(1) as it relates to the nutrition and hydration program that includes:
- Voluntary plan of correction (VPC) issued October 16, 2017

(2017_505103_0046) [s. 8. (1) (a),s. 8. (1) (b)]
(541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2018

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 90(2).

Specifically, the licensee shall ensure that:

a) all resident-staff communication and response system activation cords in the home are tested within 7 days of receiving this compliance order. Testing locations and test results are to be documented.

b) the home's procedure to complete monthly audits is followed in order to keep the resident-staff communication and response system in good repair.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that procedures developed to ensure the resident-staff communication and response system is kept in a good state of repair, were implemented.

During stage 1 of the Resident Quality Inspection, inspectors found the following:

Resident #002 - bathroom call bell would not activate
Inspector #622 spoke with a member of the maintenance staff who also tried to activate the call bell but could not.

Resident #032 - the call bell cord would not activate
Inspector #622 spoke with a PSW who stated they would find another cord for the call bell.

Resident #037 - bathroom call bell would not activate
Inspector #197 informed a PSW who confirmed the call bell would not activate.

Resident #026 - bathroom call bell would not activate
Inspector #197 informed a PSW who confirmed the bell did not work. The PSW indicated they would notify maintenance to have it fixed.

The Environmental Coordinator indicated that the home does have a process to audit the resident-staff communication and response system and provided a blank copy of the audit sheets, as well as the written process. They indicated that auditing the system is their responsibility and that it is to be done monthly. The Environmental Coordinator indicated to the inspector that monthly audits had not been completed yet for 2018.

The severity of this issue was determined to be a level 3 as there was potential for actual harm to the residents whose resident-staff communication and response system failed to function. The scope of the issue is a level 1, ten percent of the resident population inspected were affected. The home has a level 2 history as they have 1 or more unrelated NC in last 36 months. [s. 90. (2) (b)]
(197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Heath Heffernan

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