Ontario

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2019	2019_520622_0027	019400-19	Complaint

Licensee/Titulaire de permis

Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street Suite 2100 TORONTO ON M5J 2S1

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), EMILY BROOKS (732), MANON NIGHBOR (755)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 14, 15, 19, 20, 21, 22, 25, 26, 28, 29, 2019.

The following log was completed during this inspection:

Complaint Log #019400-19/IL-70876-OT related to resident care and services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Long-Term Care/UniversalCare, the Quality Control and Risk Manager,the Office Manager, the Registered Nurse Practioner/Skin and Wound Champion, the RAI Coordinator, the Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), the scheduling clerk and the residents.

Also during the inspection, the inspectors reviewed electronic and hard copy health records, registered and non-registered staff schedules and payroll documents, the licensee's staffing plan, the licensee's staff contingency plan, Union - Long-Term Care Professional Responsibility Workload Forms, pertinent correspondence between the licensee and the Union, the licensee's policies related to the Falls Prevention and Management Program # NUR 05-02-02 and Medication Ordering #04-03-02, Fall Committee Meeting Minutes, resident bath lists, the licensee's 24 hour report sheets, medication incident forms, Medication Incident Reporting and made observations of resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

4 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. 6. Plan of care

Specifically failed to comply with the following:

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee shall ensure that the care set out in the plan of care related to walking in their room, the corridor, and locomotion on the unit, is provided to resident #003 as specified in the plan.

On November 25, 2019, inspector #622 reviewed the 24-hour care plan on the hard copy of the health record for resident #003 which indicated that they required one to two staff to walk in their room and corridor and extensive assistance by staff for locomotion on the unit. The electronic care plan on Point Click Care stated that resident #003 was at high risk for falls.

During an interview with inspector #622 on November 26, 2019, Physiotherapist #122 stated that they had assessed resident #003 as requiring one staff for ambulation at all times.

During an interview with inspector #622 on November 26, 2019, full time, Registered Nurse (RN) #101 who had worked when resident #003 fell on a specified date, stated that resident #003 had been ambulating independently when they fell that date. RN #101 stated that resident #003 was independent for ambulation and that they ambulate all the time on their own. RN #101 stated that resident #003 would require one on one supervision as they get up and go on their own all the time.

During an interview with inspector #622 on November 26, 2019, Director of Care (DOC) #100 stated that the plan of care encompasses all documentation. Resident #003's

current plan of care would include the 24-hour care plan on the hard copy health record and the electronic care plan on Point Click Care. DOC #100 reviewed resident #003's 24-hour care plan on the hard copy health records and stated that one to two staff to walk in their room and corridor and extensive assistance by staff for locomotion on the unit for resident #003 was not possible as the resident wandered without assistance all the time. DOC #100 stated the plan of care for resident #003 was not being followed.

Therefore, the licensee failed to ensure that the plan of care for resident #003 was followed. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in resident #010's plan of care was documented.

Review of resident #010's bath schedule indicated that they were bathed on two specified days of the week. Inspector #732 reviewed resident #010's care record for one a one month period. It was noted that for a specified date, there were no initials on resident #010's intervention titled "ADL-Bathing".

Inspector #732 spoke to PSW #121, who worked the day shift of the specified date. PSW #121 could not confirm if the resident had or had not received a bath as they did not recall that shift, but indicated that resident #010 often refused their bath. When asked what a blank space indicated on the care record, PSW #121 informed Inspector #732 that it was most likely because nothing was documented. Inspector #732 spoke to PSW #119 who indicated that the spaces should not be left blank, and if a resident refuses a bath, there was a spot to check this off. PSW #120 also informed Inspector #732 that if there is no initial under an intervention it was because documentation was missed, and that this often occurs when they are short staffed.

Therefore, the licensee has failed to ensure that resident #010's bath was documented. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan,, to be implemented voluntarily.

WN #2: 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 licensee has failed to ensure that resident #001 was bathed, at a minimum, twice a week by the method of their choice.

A complaint received by the Ministry of Long-Term Care on a specified date, stated that residents were not receiving baths twice weekly due to staffing shortages.

On a specified date, Personal Support Worker (PSW) #104 approached inspector #622 and inspector #755. PSW #104 stated that they had noted that the staffing levels in the home were short, especially on weekends. They stated that there were three PSW staff on a specified weekend during the evening shift for two of the three specified wings. PSW #104 stated that they did not know which residents were not bathed however were aware that baths had been missed.

On November 21, 2019, inspector #622 reviewed the bath schedule for one of the specified wings which stated that resident #001 was to receive a bath twice weekly on specified dates during the evening shift.

On November 21, 2019, inspector #622 reviewed the Point of Care documentation for resident #001 on Point Click Care dated for the specified week. There was no

documentation to indicate that a bath had or had not been completed on the specified date, nor was there documentation to indicate the bath had been rescheduled to another date.

On November 21, 2019, inspector #622 reviewed the progress notes for the specified date, there was no documentation to indicate that a bath had or had not been given, or refused.

During an interview with inspector #622 on November 20, 2019, resident #001 stated that they have tub baths on two specified evening shifts. Resident #001 stated that they have missed baths a few times including the specified date. Resident #001 stated that the bath was not re-scheduled and they had not received a sponge bath.

During separate interviews with inspector #622 on November 25, 2019, Personal Support Workers (PSW) #120 and PSW #122 stated that documentation of baths would be completed on Point of Care. Resident #001 had not received their bath on the specified date during evening the shift because of short staffing. PSW #120 stated if baths have not been completed, they report to the registered staff who give direction for sponge baths and sometimes rescheduling the bath to another shift. PSW #122 stated that resident #001 was not given a sponge bath on the specified date. PSW #120 and PSW #122 were not aware if resident #001's bath had been rescheduled to another date.

During an interview with inspector #622 on November 26, 2019, Registered Nurse (RN) #110 who worked on the second floor during the evening shift on the specified date, stated that they were not aware that resident #001 had not received their bath that evening. RN #110 stated to their knowledge, the bath was not rescheduled.

During an interview with inspector #622 on November 26, 2019, Director of Care (DOC) #100 stated if baths could not be completed it would be on Point of Care which would send an alert. PSW staff work together to move care to the next shift when care can not be done. DOC #100 stated that they were not aware that resident #001 had not received their bath on the specified date. DOC #100 indicated on the specified date, if the bath was not given to resident #001 and not passed on or rescheduled, staff had not followed the process in place for when the care cannot be completed during their shift, and resident #001 had not received their two baths weekly. [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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents #003 and #008 have fallen, the residents are assessed and that where the condition or circumstances of the residents require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

According to a complaint received by the Ministry of Long-Term Care, residents at high risk of falls were not being monitored in accordance with their falls prevention measures and were experiencing an increased number of falls with significant injury.

On November 22, 2019, inspector #622 reviewed the electronic plan of care on Point Click Care for resident #003, which stated that they were at risk for falls characterized by history of multiple falls with multiple risk factors – Morse fall score which indicated high risk for falls.

On November 22, 2019, inspector #622 reviewed the progress notes for resident #003

which stated that they had fallen twice to their hands and knees without injury on a specified date. Further review of the progress notes indicated that resident #003 had fallen multiple times after the specified date, sustaining an injury with hospital transfer during their latest fall.

On November 25, 2019, inspector #622 attempted to review the risk management tab on Point Click Care for documentation related to resident #003's two falls on the specified date, there were no risk management notes documented for resident #003's related to that date.

On November 25, 2019, inspector #622 reviewed the Assessment tab on Point Click Care for the two falls resident #003 sustained on the specified date. There were no post fall assessments including the Morse Fall Scale or Post Fall Huddles found for that date.

During an interview with inspector #622 on November 25, 2019, the Director of Long-Term Care/Universal Care #106 and the Quality Control and Risk Manager #107 stated that post fall assessments were completed when residents fall. They stated that the post fall assessment included the Risk Management and the Morse Fall Scale.

During a telephone interview with inspector #622 on November 22, 2019, Registered Nurse (RN) #101 stated that post fall assessments are completed by the registered staff on the date the resident falls. RN #101 stated that they had not completed the Risk Management notes, the Morse Fall Scale and the Post Fall Huddle on the specified date when resident #003 fell twice because it was a busy shift.

During an interview with inspector #622 on November 26, 2019, DOC #100 reviewed the post fall assessment documentation on Point Click Care for resident #003 regarding their two falls on the specified date and stated that there had not been a Risk Management note, Post Fall Huddle or Morse Fall Scale completed for the fall on the specified date. DOC #100 further indicated that there had not been post fall assessments completed for falls resident #003 sustained on two further dates as well.

On November 28, 2019, inspector #622 reviewed the hard copy plan of care which stated resident #008 was a high risk for falls related to a specified diagnosis, unsteady gait, and history of multiple falls.

On November 29, 2019, inspector #622 reviewed the progress notes for resident #008

which stated they had fallen twice on a specified date with injury during the second fall.

On November 28, 2019, inspector #622 reviewed the post fall assessment documentation located on Point Click Care for the two falls which resident #008 sustained on the specified date. The documentation included a Risk Management note which linked the Morse Fall Scale to four separate specified fall dates; (the initial specified fall date and three later falls). Furthermore, it was noted that the Morse Fall scale included within the initial specified fall Risk Management note had been completed for the latest of the four specified fall dates and therefore there were no Morse Fall Scales completed for the initial specified fall date or two of the three later falls.

During an interview with inspector #622 on November 29, 2019, Director of Care (DOC) #100 stated that post fall assessments were to be completed by registered staff after each fall within the same shift. DOC #100 stated that the tools used to complete the post fall assessment where the Risk Management notes on Point Click Care which triggered the Morse Fall Scale, the Post Fall Huddle and the Head to Toe skin assessment if it was warranted.

On November 29, 2019, DOC #100 reviewed the post fall assessment documentation on Point Click Care for resident #008. DOC #100 stated that post fall assessments had not been completed for resident #008 when they had falls on three specified dates.

It was determined that resident #003 sustained falls on three specified dates and Resident #008 sustained falls on three specified dates for which post fall assessments were not completed. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls,, to be implemented voluntarily.

WN #4: 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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date, the prescription to change the frequency of a specific medication was written in resident #005's health record, physician's orders section. The order was to decrease the frequency of the specific medication. The previous order of this specific medication was not discontinued as per the Medication Administration Record (MAR) in MedeCare.

On Nov 26, 2019, Inspector #755 interviewed Registered Practical Nurse (RPN) #112, who stated that they noticed a duplicate order for a specific medication and filled out an incident report. The date after the order was received, it was documented in the electronic MAR that the medication was administered to resident #005 four times daily as per the previous frequency instead of three times daily as per the new frequency ordered by the physician.

During an interview with RPN #112, they stated that they documented the administration of this specific medication on the date following the receipt of the order, but could not be certain they administered it and added that it was possible to redact documentation of a medication administration. This specific medication order was written on the specified date and signed by a Registered Nurse two days later.

Inspector #755 interviewed RPN #113 on Nov 26, 2019, who stated that they don't have time to verify orders on the chart, they administer what is on the MAR.

There was no ill effect noted to resident #005 as a result of the medication incident.

Resident # 002 was prescribed a treatment on a specified date, twice daily and resident #004 was prescribed a treatment on a specified date to be applied twice daily. On a specified date, resident # 002 and #004 were not administered their treatment at 0900 hours.

A second incident occurred when resident # 002 was ordered a treatment on a specified date, twice daily and resident #004 was ordered a treatment on a specified date to be applied twice daily. On a specified date, resident # 002 and #004 were not administered their treatment at 0900 hours.

A third incident occurred when resident # 002 was ordered a treatment on a specified date, twice daily and resident #004 was ordered a treatment on a specified date to be applied twice daily. On a specified date, resident # 002 and #004 were not administered their treatment at 0900 hours and 1801 hours.

During interview, November 21, 2019, with Registered Nurse (RN) #114, they explained that they were too busy to administer skin related treatments to residents on a specified date when they were short staffed.

Therefore, the licensee has failed to ensure that drugs were administered to residents #002, # 004 and #005, 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 12th day of December, 2019

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

Original report signed by the inspector.