Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 7, 2016	2016_263524_0040	031068-16	Resident Quality Inspection

Licensee/Titulaire de permis

LUTHERAN HOMES KITCHENER-WATERLOO
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

TRINITY VILLAGE CARE CENTRE
2727 KINGSWAY DRIVE KITCHENER ON N2C 1A7

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

INA REYNOLDS (524), ADAM CANN (634), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 29, 30, December 1, 2, 5, 2016.

The following intakes were completed within the RQI:
Log # 005437-16 CI 2580-000029-15 related to Falls Prevention and Management
Log # 033300-16 CI 2580-000024-16 related to Falls Prevention and Management
Log # 025785-16 Follow-up to CO # 001 related to Abuse Investigation
Log # 025786-16 Follow-up to CO # 002 related to Duty to Protect

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, the Assistant Director of Resident Care, the Clinical Auditor, the Resident Assessment Instrument (RAI) Coordinator, two Registered Nurses, five Registered Practical Nurses, four Personal Support Workers, the Residents' Council Representative, a Family Council Representative, 20 residents and three family members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, medication administration, a medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, reviewed relevant investigation notes and policies and procedures of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2016_258519_0006	519
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2016_258519_0006	519

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

Record review of a Critical Incident Systems Report submitted to the Ministry of Health and Long-Term Care on a specific date, indicated that an identified resident had an incident which resulted in an injury. Investigation notes stated a Personal Support Worker (PSW) had placed the resident on a personal assistive device on specific date and time. The PSW said that they had left the resident's room and told the oncoming shift that the resident was on the personal assistive device. The oncoming shift PSW arrived at an identified time to the resident's room and found the resident lying on the floor.

Record review of the home's "Investigation Form" dated on a specific date and time, and the plan of care prior to the resident's fall indicated the resident was dependent on staff for personal care needs for their safety and could not be left unattended on the identified personal assistive device related to their diagnosis.

The Assistant Manager of Resident Care on December 2, 2016, agreed that the care set out in the plan of care for the identified resident was not provided as planned and the resident's care routines should have been followed. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) During Stage One of the Resident Quality Inspection (RQI) on November 29, 2016 and again on December 1, 2016, it was observed that an identified resident had two quarter bed rails in the raised position. A review of the plan of care revealed two quarter bed rails in use.

Record review of the resident's clinical records revealed the absence of a documented resident assessment for the use of bed rails.

Record review of the Trinity Village Bed System Measurement Worksheets indicated bed entrapment audits were completed for 2016 by maintenance staff. All bed systems were evaluated, however the Director of Resident Care stated the home had not completed a bed assessment for the identified resident using bed rails.

B) During Stage One of the Resident Quality Inspection (RQI) on November 29, 2016, it was observed that a resident had two quarter bed rails in the raised position. These two quarter bed rails were observed in the raised position throughout the RQI.

Upon interview with the resident on December 2, 2016 at 1010 hours, it was stated that they used the quarter bed rails to assist them when they moved in bed.

Upon interview with a Personal Support Worker (PSW) on December 2, 2016, it was stated that the resident used the quarter bed rails to hold on to when they assisted the resident out of bed.

During the documentation review a bed rail assessment could not be located in the resident's electronic or hard copy file.

Upon interview with a Registered Practical Nurse (RPN) on December 2, 2016, it was stated that the resident used the quarter bed rails to assist with bed mobility and when staff assisted the resident out of bed.

Upon interview with the Director of Resident Care (DORC) on December 2, 2016 at 1135 hours, it was stated that the home did not do bed rail assessments to determine the reason for their use and to minimize risk to the resident.

C) During Stage One of the Resident Quality Inspection (RQI), it was observed on November 29, 2016 at 1458 hours, that there were two quarter bed rails in the raised position on an identified resident's bed. These quarter bed rails were observed in the raised position throughout the RQI.

Upon interview with a Registered Practice Nurse (RPN) on December 2, 2016, it was stated that bed rail assessments were not completed for the resident.

Upon interview with the Director of Resident Care (DORC) on December 1, 2016, it was stated that the home did not do bed rail assessments to determine the reason for their use and to minimize risk to the resident.

The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a restraint by a physical device was included in the resident's plan of care.

Observations of a resident on November 30, December 1 and 2, 2016, revealed the resident had a device in place.

Upon interview with Personal Support Worker (PSW) on a specific date and time, it was stated that the resident used the identified device. However, the resident was unable to release the device on their own without assistance when asked by the PSW and the Inspector.

Review of the resident's plan of care revealed the absence of documentation related to the use of the device or monitoring related to use of the device as a restraint. Record review of the resident's clinical record revealed there was no physician's order or consent for the use of the device as a restraint.

Interview with the Director of Resident Care on December 2, 2016, it was stated that the use of the resident's device should be documented in the care plan and it was not. Upon interview with the Register Practical Nurse Clinical Auditor on December 5, 2016, it was stated that the identified resident would require cueing from staff to undo the device due to the residents' diagnosis and therefore the device would be considered a restraint.

The licensee failed to ensure that a restraint by a physical device was included in the resident's plan of care. [s. 31. (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 a restraint by a physical device is included in the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Documentation review for an identified resident revealed that on the admission Bowel Function Assessment on a specific date and on the Bowel Function Assessment done on another date; the resident was continent of bowels.

The Resident Assessment Instrument/Minimum Data Set (RAI/MDS), Section H for Continence, on a specific date, noted that the resident's bowel continence was coded a zero for continent. The RAI/MDS dated on an other date, noted that the resident's bowel continence was coded a one for usually continent. The RAI/MDS dated on a subsequent date, noted that the resident's bowel continence was coded a two for occasionally incontinent.

Under Bowel Incontinence in the plan of care, on a specific date, there was an entry which stated if there was a decline in continence level it was to be reported to the house manager.

Upon interview with a Registered Practical Nurse (RPN) on December 2, 2016, it was stated that on consultation with the Resident Assessment Inventory (RAI) Coordinator it would be the expectation that a bowel assessment would be done with a decline in continence.

The home's policy titled "Bowel and Bladder Function/Level of Continence Assessment", last reviewed on October 2016, stated under the procedure for Assessments - "Residents' continence level and care should be assessed within 7 days of admission and as health status effects continence".

Upon interview with the Director of Resident Care (DORC) on December 2, 2016 at 1206 hours, it was stated that a bowel assessment should have been done for the resident with a decline in continence, and that it could not be found in the resident's documentation. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident requires, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, (iv) that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

During an identified home area medication room observation on December 5, 2016 at 1050 hours, it was noted that there were two bottles of Mucillium Powder 336 grams (gm) in the upper stock medication cupboard that had expired on July 2016. In the medication room refrigerator there was a resident prescription bottle of an identified medication that had expired on November 30, 2016.

These expired medications were shown to a Registered Nurse (RN) who confirmed they were expired.

The licensee failed to ensure that drugs were stored in an area that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting) when the above medications were found expired in the upper cupboard and the refridgerator in a medication room. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs were stored in an area or a medication cart, (iv) that complies with manufacturer's instructions for the storage of the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within three business days after the occurrence of an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

A Critical Incident Systems Report was submitted by the home to the Director on a specific date. The report indicated that an identified resident had an incident on a specific date and was transferred to hospital. A record review was completed of the progress notes in the residents' electronic chart which revealed that the home was made aware that the resident had an incident that caused an injury after the occurrence.

An interview was conducted with the Director of Resident Care (DORC) on December 2, 2016 at 1130 hours. The DORC said that the home did not report the incident to the Ministry of Health and Long-Term Care within three business days.

The licensee failed to ensure that the Director was informed within three business days of an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition. [s. 107. (3.1)]

Issued on this 19th day of December, 2016

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

Original report signed by the inspector.