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

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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
Mar 9, 2017	2017_323130_0006	003472-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

GARDEN CITY MANOR
168 Scott Street St. Catharines ON L2N 1H2

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583), ROSEANNE WESTERN (508), YULIYA FEDOTOVA (632)

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): February 9, 10, 13, 14, 15 , 16, 17, 21, 22, 23, 24, 27, 28, March 1, 2 and 3, 2017

During this inspection, the home was toured, meal service and care was observed, clinical records, investigation reports, employee files and relevant policies and procedures were reviewed.

The following Follow-up inspections were conducted concurrently with the RQI: 014844-16 related to s.20 (1), 014845-16 related to s.19 (1) and 014854-16 related to s.6 (7).

The following onsite Inquiries were conducted concurrently with the RQI: 008496-16, 028431-16, 029969-16, 010448-16, 034265-16, 034265-16, 027497-16, 003592-17 and 000128-17 related to allegations of neglect and abuse; 027216-16 and 017816-16 related to falls management; 027216-16 and 007381-16 related to continence care; 032469-16 related to medications and 002418-17 related to odours.

The following Complaint inspections were conducted concurrently with the RQI; 004254-16 related to falls management, continence care and plan of care; 012387-16 related to staffing; 032537-16 related to admissions and discharges; 035262-16 related to retaliation and 004326-17 related to medication administration.

The following Critical Incident inspections were conducted concurrently with the RQI : 004254-16, 028592-16, 035296-16, 016422-16, 012820-16 and 001688-17 related to falls management; 018812-16, 019169-16 related to continence care; 019590-16 related to improper care; 020610-16 related to call bell response time; 023208-16 related to residents' rights and 014278-16, 024041-16, 015148-16, 016037-16, 030311-16, 009605-16, 030530-16, 019587-16, 024531-16, 009801-16, 009389-16, 007285-16, 029283-16, 009389-16, 007285-16, 029283-16, 017396-16, 012820-16, 031972-16, 002194-17 and 002194-17, related to allegations of neglect and abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate DOC (ADOC), Business Manager, Environmental Services Manager (ESM), Activation Manager, Registered Dietitian (RD), Dietary Manager, dietary staff, Physiotherapist (PT), registered nursing staff, personal support workers (PSWs), President of Residents' Council, Representative of Family Council, residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **3 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_247508_0004	130
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2016_247508_0004	130
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2016_247508_0004	130

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) A Critical Incident System (CIS) submitted by the home, indicated in 2017, resident #168 received assistance from one staff member to get from their bed to the bathroom. The resident self ambulated with an aid back to their bed, when staff completed another task. The resident lost their balance and fell resulting in injury.

A review of a Safety Assessment for Lifts and Transfers (SALT) conducted by the home in 2017, indicated that the resident was assessed as requiring one person supervision for their transfers. A review of a Physiotherapy assessment conducted in 2017, indicated that the resident required the assistance of one person for transfers and required moderate assistance. The Physiotherapy assessment indicated that the resident was ambulatory with a rollator walker with one person assistance and required cueing.

An interview with the DOC confirmed that staff had not used safe transferring techniques when assisting resident #168.

Please note: This non-compliance was issued as a result of a CIS Inspection #001688-17, which was conducted concurrently with the RQI Inspection. (Inspector #214).

B) A Critical Incident System (CIS) submitted by the home, indicated that in 2016, resident #023 was transferred from their wheelchair to their bed via a mechanical lift. The mechanical lift caused a minor injury to the resident. The mechanical lift was placed out of service for assessment by the vendor.

An interview with the DOC confirmed that the vendor of the mechanical lift assessed the equipment and found no malfunctions. The DOC confirmed that when the staff transferred the resident onto their bed, they failed to follow the proper procedure resulting in an injury to the resident. The DOC confirmed that the resident was not transferred using safe transferring techniques.

Please note: This non-compliance was issued as a result of a CIS Inspection #012820-16, which was conducted concurrently with the RQI Inspection. (Inspector #214). [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

A) The plan of care for resident #190 indicated the resident required assistance of one staff for a specific activity of daily living (ADL). In 2016, the home submitted a CI to report the resident had not received assistance with the ADL on a specified date in 2016, over an eight hour period. It was confirmed by the DOC and the point of care records that the resident had not been assisted with the specific task during the specified time period. A skin assessment conducted by registered staff #824, confirmed the resident had acquired a minor alteration in skin.

The DOC confirmed resident #190 did not receive assistance with an ADL to remain clean, dry and comfortable.

Please note: This non compliance was issued as a result of CI inspection #014278-16, which was conducted concurrently with the RQI. (Inspector #130).

B) On a specified date in 2016, staff #634 reported to co-workers that resident #194 had been incontinent of urine during the night and was found in a wet incontinence product.

Staff #747 who was responsible for caring for resident #194 confirmed to co-workers and to the ADOC that they had not changed the resident's incontinent product. Staff #747 stated that they were waiting for the resident to call for assistance and did not provide brief changes when doing rounds.

It was confirmed through documentation and during an interview with the DOC that the resident who required continence care products did not have sufficient changes to remain clean, dry and comfortable.

Please note: This non compliance was issued as a result of CI inspection, #018812-16 which was conducted concurrently with the RQI. (Inspector #508).

C) On a specified date and time in 2016, it was reported by a PSW that resident #114 and resident #156 were found by PSW staff to be saturated with urine. Both residents were frequently incontinent and required incontinent product changes during a specified shift.

The home conducted an investigation and it was determined that staff did not provide the incontinent product changes that these residents required on a specified shift.

It was confirmed by the DOC that the residents did not have sufficient changes to remain clean, dry and comfortable.

Please note: This area of non compliance was issued as a result of CI inspection #019169-16, which was conducted concurrently with the RQI. (Inspector #508). [s. 51. (2) (g)]

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 residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A) Resident #148 had identified responsive behaviours. On a specified date in 2017, resident #148 demonstrated responsive behaviours towards co-resident #148, which resulted in injury to resident #198. It was confirmed during an interview with the DOC that steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Please note: This area of non compliance was issued as a result of CI inspection, #000128-17, which was conducted concurrently with the RQI. (Inspector #508).

B) The home submitted a CI in 2016, to report an altercation between resident #100 and resident #099. According to the CI, on a specified date in 2016, resident #100 demonstrated responsive behaviours towards resident #099.

A review of the clinical record confirmed that resident #100 had a known history of responsive behaviours when specific triggers were present. The resident had demonstrated responsive behaviours in two prior incidents, which occurred in 2016.

The DOC confirmed that specific triggers for resident #100's responsive behaviours were known to staff.

The DOC confirmed that the resident shared a room with #099, and that steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, prior to the reported incident in 2016.

Please note this non compliance was issued as a result CI inspection # 016037-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A) A CI submitted by the home indicated that on a specified date in 2016, resident #028 sustained a fall with injury.

A review of the resident's written care plan, in place at the time of the incident, indicated that staff were to ensure specific interventions were implemented at a specified time. A review of this task in the Point of Care (POC) documentation system indicated that staff had documented on a specified date in 2016, that a specified intervention had been implemented.

A review of the resident's current written plan of care for falls identified interventions that were to be in place at a specified time. The resident was observed on a specified date in 2017, however the interventions had not been implemented. Registered staff #727, who also observed the resident, confirmed that as per the resident's current care plan, a specific intervention was to be in place, but was not. Registered staff #727 informed registered staff #616, who then spoke with front line staff #744, who indicated that they had informed the nurse the week prior that the intervention had not been in place. An interview with the PT also confirmed that they had assessed the resident and determined the intervention was required.

Care was not provided to resident #028, as specified in their plan.

Please note: This non-compliance was issued as a result of a CIS Inspection #028592-16, which was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident`s care needs changed or care set out in the plan was no longer necessary

A) In 2017, resident #029 was observed to be wearing their glasses. Staff #636 and #663 indicated that the resident wore their glasses when they wanted to. A review of the resident's most recent Minimum Data Set (MDS) assessment, in 2017, indicated the resident had not been coded as requiring any visual appliance, which included glasses. A review of the resident's current written plan of care indicated under visual function that the resident chose not to wear glasses. An interview with registered staff #825 confirmed that the resident had been wearing their glasses for at least the last two weeks. An interview with Registered staff #824 confirmed that they were not aware that the resident wore their glasses when they wanted to and had not identified this on the most recent MDS coding assessment. An interview with the DOC confirmed that the resident's plan of care had not been reviewed and revised when their care needs changed. (Inspector #632). [s. 6. (10) (b)]

WN #5: 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with r. 49(1) which required every licensee of a long-term care home to ensure that the falls prevention and management program, at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A) A review of the home's policy titled, "Fall Prevention and Injury Reduction" (CARE5-P10 with an effective date of August 31, 2016) indicated that the home used a Fall Risk Assessment Tool (FRAT) to identify the resident's risk of falling.

A review of the FRAT indicated the tool was completed on admission and with a significant change in status.

A CI submitted by the home, indicated that in 2017, resident #168 was receiving assistance from one staff member to get from their bed to the bathroom. The resident self ambulated with an aid back to their bed, while staff completed another task. The resident lost their balance and fell, resulting in injury.

A review of the resident's assessments in POC indicated that a FRAT had not been completed for resident #168 when they demonstrated a significant change in their health status.

The DOC confirmed that home had not complied with their Falls Prevention and Injury Reduction policy.

Please note: This non-compliance was issued as a result of a CIS Inspection #001688-17, which was conducted concurrently with the RQI Inspection. (Inspector #214).

B) A review of the home's policy titled, "Fall Interventions Risk Management (FIRM) Program" (LTC-E-60 with a revised date of March 2014) indicated the following:

i) The nurse would complete a Falls Risk Assessment Tool (FRAT) within 24 hours of the resident's admission and documented on the care plan. The FRAT could be repeated as required, as per change in resident's condition.

A review of the FRAT indicated the tool was to be completed on admission and with a significant change in status.

A CI submitted by the home for an injury that resulted in transfer to hospital and a significant change in the resident's health status, indicated that in 2016, resident #130 was transferred by staff to the washroom. The resident requested staff to leave and that they would ring their call bell when they were finished. The staff returned to the nursing station when they heard the resident calling out. The resident had transferred themselves independently back to their bed; lost their balance and fell to the floor, which resulted in injury.

A review of assessments in Point Click Care (PCC) indicated that a FRAT had not been completed until some time later in 2016.

The DOC confirmed that home had not completed a FRAT tool when the resident had a significant change in their health status and that the home had not complied with their Fall Interventions Risk Management Program policy.

Please note: This non-compliance was issued as a result of a CIS Inspection #016422-16, which was conducted concurrently with the RQI Inspection. (Inspector #214). [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

A) In 2016, the home submitted a CI, which indicated resident #077, had alleged they were assaulted in their bed. The home investigated the incident and confirmed through interviews and video surveillance that on the specified date in 2016, co- resident #089 entered the resident's room and was found by staff #681, at the resident's beside, holding a specified body part. Resident #077 was assessed following the incident and observed to have injuries to specified locations. Resident #077 confirmed they felt fearful after the incident. Information gathered from the clinical record of resident #089, confirmed they had a known history of unprovoked responsive behaviours.

This information was confirmed by the DOC.

In 2016, resident #077 was not protected from abuse by anyone. At the time of this incident, the home had an outstanding Compliance Order related to s. 19 (1), which was issued on February 11, 2016, with a compliance date of August 1, 2016.

Please note: This non compliance was issued as a result of CI:009605-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 19. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) In 2016, resident #162 exhibited responsive behaviours towards resident #032, which resulted in a minor injury to resident #032. The DOC confirmed that the incident was documented in resident #162's clinical record, but was not documented in the clinical record of resident #032. The DOC stated a Risk Management Form was completed for resident #032, which detailed a description of the incident; however, this form was not retained as part of the resident's permanent record.

It was verified by the DOC, that not all actions taken with respect to the incident involving resident #032, in 2016, under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Please note: This non compliance was issued as a result of CI: 030311-16, which was conducted concurrently with the RQI. (Inspector #130).

B) Resident #200 had an intervention in place which required routine action by registered staff. On a specified date in 2016, staff #824 performed the required action as ordered, but had not documented their action.

It was confirmed by staff #824 and the ED during interviews in 2017, that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions had not been documented.

PLEASE NOTE: This area of non compliance was issued as a result of CI inspection #004376-17, which was conducted concurrently during this RQI. (Inspector #508). [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

A) Resident #131 had an individualized preferred sleep routine and pattern related to issues with pain and comfort. The resident was totally dependent on two staff for transferring in and out of bed. The resident had specific times to be transferred out of bed in the morning, into bed at night and as requested throughout the day.

On a specified date in 2016, resident #131 was up in their wheelchair and requested to be put back to bed. Registered staff #629 asked staff #619 to put the resident back to bed. Staff #619 responded by saying that the resident was going to have to wait a long time.

The home's internal investigation confirmed that the resident had requested to be put back to bed twice between a specific time period; however, staff did not put the resident back to bed as requested.

It was confirmed by review of the documentation and by the ED, that the resident's desired bedtime and rest routines were not supported to promote comfort, rest and sleep.

PLEASE NOTE: This area of non compliance was issued as a result of CI #020610-16, which was conducted concurrently with the RQI. (Inspector #508). [s. 41.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care home Service accountability agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in Applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care".

(A) In 2017, nursing staff #674 was observed completing laundry duties (delivering personal laundry to resident rooms). The staff #674 verified that delivery personal laundry was a regularly assigned duty.

The ED confirmed that the Laundry Delivery Aide position was paid out of the NPC Envelope. (Inspector #130). [s. 101. (4)]

2. The licensee did not comply with the conditions to which the licence was subject. The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN), under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system.
Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the ARD of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents and , RAPs to be generated and reviewed and RAP assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD). (RAI-MDS Data) – 8.1(c)(ii).

A) The MDS Significant Correction of Prior Full Assessment completed on a specified date in 2016, for resident #116, was coded "0" (zero) under Section E. Mood and Behaviours 1(a) and 1(m), indicating, the indicator was not exhibited in the previous 30 days; however, progress notes reviewed over a specified time period indicated they had exhibited indicators specified in this section of the assessment.

The Modified Resident Assessment Protocol (RAP), 08. Mood State and 09. Behavioural Symptoms, completed for the same assessment period stated the resident's behaviours had improved "this 3/12" (first three of twelve months). It stated the resident had not exhibited the specified behaviours over the review period; however, progress notes reviewed over a specified time period in 2016, indicated the resident had demonstrated the behaviours on a number of occasions. One recorded incident had resulted in injury to a co-resident; another incident required the presence of an outside agency and the need for continuous supervision.

The Assessor did not accurately code Section E. Mood and Behaviours for resident #116 when completing the RAI MDS tool on in 2016, to produce an accurate assessment of the resident.

The Modified RAPs triggered for Mood State and Behavioural Symptoms did not accurately reflect exhibited responsive behaviours.

This information was confirmed by the DOC.

Please note this non compliance was issued as a result of CI inspection #009389-16, which was conducted concurrently with the RQI. (Inspector #130).

B) The MDS Significant Change in Status assessment completed in 2016, identified in the RAP 09. Behavioural Symptoms, that resident #089 could demonstrate a specific responsive behaviour and indicated they had improved with most of their previous behaviours. Progress notes reviewed for the previous 90 days indicated the resident had demonstrated responsive behaviours, which had resulted in injury to a co-resident and the need for constant supervision to ensure the ongoing safety of co-residents and staff.

The Modified RAP triggered for Behavioural Symptoms did not accurately reflect responsive behaviours exhibited for the 90 days of the ARD. This information was confirmed by the DOC.

Please note this non compliance was issued as a result of CI: 009801-16, which was conducted concurrently with the RQI. (Inspector #130). [s. 101. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

A) An interview with a family member of resident #191, identified that they had concerns in relation to how the home managed their complaints regarding the care needs of their loved one.

A review of the resident's progress notes indicated that on a specified date in 2016, the resident's family had verbalized a complaint to front line staff regarding the care of the resident. Documentation indicated that this complaint was relayed to a manager in the home. Further review of the documentation indicated that the manager had documented in 2016, that they had made attempts to contact the family on a specified date in 2016 and were only able to leave a message. No further documentation was identified that any further attempts were made to contact the family following the initial attempt.

A review of the home's policy, titled, "Management of Concerns/Complaints/Compliments" (LP-B-20 with a revised date of October 2014) stated on page 3, "If concerns cannot be resolved immediately at point-of-service, the individual who is first aware of a concern will initiate the Client Service Response Form. A copy of the initial form will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern".

A review of the home's documentation binder in which complaints and concerns were logged, identified that no complaints in relation to the resident's care needs had been logged, including any time frames for actions to be taken or any follow up action required.

An interview with the ED confirmed that a documented record had not been kept in the home that included time frames for actions to be taken or any follow up action required.

Please note: This non-compliance was issued as a result of Complaint Inspection #004254-16, which was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 101. (2)]

WN #11: 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 failed to ensure that drugs were stored in an area or a medication cart that complied with the manufacturer's instructions for the storage of the drugs.

A) In 2017, during an observation of the medications stored in a cabinet located in a locked room on the second floor outside a specific home area, it was identified that some medications had passed their expiration dates. Two identified medicatons had expiration dates of 2015.

It was confirmed by staff #639 that this cabinet was accessible to all registered staff to stock their medication carts as needed.

It was confirmed through observation and by staff #639 in 2017, that drugs were not stored in an area that complied with the manufacturer's instructions for the storage of the drugs. (Inspector 508). [s. 129. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

A) A review of resident #191's electronic progress notes indicated that the home was made aware in 2016, that the resident was being discharged. The resident's paper copy of their clinical record was requested; however, the DOC and ED indicated that the resident's records were stored off site and could not be located during the time of this inspection.

Please note: This non-compliance was issued as a result of Complaint Inspection #004254-16, which was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 233. (1)]

Issued on this 2nd day of April, 2017

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

Original report signed by the inspector.