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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 15, 2018;	2017_546585_0025 (A3)	028891-17	Resident Quality Inspection

Licensee/Titulaire de permis

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

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

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

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

LEAH CURLE (585) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

No amendments were made in this Amended Public Copy inspection report.

Issued on this 15 day of February 2018 (A3)

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

Original report signed by the inspector.

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

LEAH CURLE (585) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): December 18, 19, 20 and 21, 2017.

Concurrent to this RQI, one complaint inspection log #017173-16 was conducted regarding admissions refusal, as well as three on-site Critical Incident System (CIS) inquiries: CIS log #008041-17 regarding alleged staff to resident abuse; CIS log #021294-17 regarding failure/breakdown of major system - resident staff communication and response system; and CIS log #025948-17 regarding alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Families, Personal Care Providers (PCPs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Nurse Managers, environmental staff, dietary staff, the Resident Assessment Instrument (RAI) Coordinator, Social Worker, Environmental Service Manager, Program and Service Manager, Assistant Director of Care (ADOC), Co-Directors of Care (Co-DOCs), and the Administrator.

During the inspection, the inspector(s) toured the home, observed the provision of resident care and services, reviewed resident clinical records, meeting minutes, program evaluations, training records as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Residents' Council

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

- **4 WN(s)**
- **1 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	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. 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage

bowel and bladder continence based on the assessment and that the plan was implemented.

Resident #009 was admitted to the home in 2017. Their admission Minimum Data Set (MDS) assessment identified they required assistance from staff for toileting and that they experienced a specified level of bowel and bladder incontinence. The home initiated a Bladder Continence Assessment and Bowel Continence Assessment, which noted the resident's level of bowel and bladder continence. The assessments identified the use of incontinent product, level of assistance required with toileting and how the resident was to be toileted. The assessments also identified that the resident's care plan related to continence had been reviewed, revised and was current in addressing their care needs related to bowel and bladder management.

The home's policy, "Continence Care - policy number LTC-WQ-200-02-05", revised December 2017, directed staff that five days after admission, the Continence Observation Form was to be reviewed by the registered staff, the level of continence was to be determined and a plan of care in response to the pattern of continence was to be developed and documented. The care plan must include:

a) The resident's level of continence for both bladder and bowel,
b) Frequency of toileting and individual patterns of toileting for bladder and bowel,
c) Retraining strategies and interventions,
d) Fluid intake,
e) Factors contributing to incontinence such as coughing, sneezing, etc,
f) Incontinence management strategies if indicated,
g) Risk factors and interventions for constipation,
h) Method of toileting including habit or routine to follow, barriers to the resident using the washroom dependently such as wheelchair bound, difficult clothing,
i) Safety issues or concerns,
j) Medications,
k) Presence or history of infections affecting bladder function,
l) Cognitive ability related to the urge to void or the ability to use the toilet,
m) Difficulty with verbalizing the need to void; and,
n) The reasons why the resident is not toileted if not toileted.

Review of the resident’s written plan of care from admission as well as several months later only included the resident's level of bowel and bladder continence.

Co-Director of Care (Co-DOC) #002 and Registered Practical Nurse (RPN) #105 reviewed the clinical record and confirmed that the written plan of care did not meet the minimum expectations of the home to include all items as identified in the home's Continence Care policy. Co-DOC #002 confirmed the expectation of the home was to include an individualized toileting plan based on their needs for each resident and staff had not included an individualized toileting plan based on resident #009. [s. 51. (2) (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 and ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Resident #009's admission Minimum Data Set (MDS) assessment identified they experienced a specified level of bowel and bladder incontinence.

On a specified date in 2017, the home initiated an admission Bladder Continence Assessment that specified the resident's level of bladder continence. One week later, a second admission Bladder Continence Assessment was completed which noted their bladder continence level had worsened.

On a specified date in 2017, the home initiated an Admission Assessment and identified the resident's level of bowel continence. One week later, a Bowel Continence Assessment form was completed and identified the resident's bowel continence level had worsened.

During an interview with RPN #105, they were unable to identify which of the assessments were correct and confirmed there were no significant changes to the resident’s condition at the time of admission and shortly thereafter. Registered Nurse (RN) #107 confirmed the resident's level of bowel and bladder continence on admission and that the further assessments were not consistent with or complemented each other. Co-DOC #001 confirmed the assessments were inconsistent and it was the expectation of the home that assessments were to involve staff to collaborate on the care of the resident to ensure the assessments were consistent and complemented each other. [s. 6. (4) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

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 failed to ensure that a written record was kept relating to the evaluation of the Continence Care and Bowel Management program under paragraph 3 that included 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.

The home's 2016 annual evaluation of the Continence Care and Bowel Management program was reviewed and did not include a summary of the

changes made to the program and the date the changes were implemented. During an interview with the Administrator and Co-DOC #2, they confirmed these components had not been included in the annual evaluation. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) On two specified dates in 2017, resident #002 was observed using a specified device. Their plan of care identified they used the device as a personal assistance services device (PASD) and for staff to reposition at specified periods; however, the clinical record did not include documentation to verify that care was provided with respect to repositioning. RPN #108 and PCP #115 were interviewed and confirmed the device was used as a PASD. Co-DOC #001 confirmed in an interview there was no documentation to verify that care was provided with respect to repositioning.

B) On two specified dates in 2017, resident #007 was observed using two specified devices. Their plan of care identified they used the devices as PASDs and directed staff to reposition at specified periods; however, the clinical record did not include documentation to verify that care was provided with respect to repositioning. RPN #107 and PCP #106 were interviewed and confirmed the devices were used as PASDs. Co-DOC #001 confirmed in an interview there was no documentation to verify that care was provided with respect to repositioning.

C) On two specified dates in 2017, resident #005 was observed using a specified device. Their plan of care identified they used the device as a PASD and directed staff to reposition at specified periods; however, the clinical record did not include documentation to verify that care was provided with respect to repositioning. RPN #108 and PCP #115 were interviewed and confirmed the device was used as a PASD. Co-DOC #001 confirmed in an interview there was no documentation to verify that care was provided with respect to repositioning. [s. 30. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to comply with Long-Term Care Homes Act (LTCHA) 2007, Chapter 8, Subsection 44. Authorization for admission to a home.

The license specifically failed to comply with the following:
s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

In 2016, the home received admission application documentation for applicant #010. A letter of refusal to admit the applicant was sent to the applicant's family and included the reason(s) why the home refused to admit. The letter stated that the applicant had specified care needs which would be more than the home would be able to effectively manage. LTC Homes Inspector #585 reviewed the admission application documentation in the home as well as the home's refusal letter. Co-DOC #002 and the Social Worker were interviewed and confirmed the home had the staff and resources available which would indicate the home had the ability to provide care to the resident. As a result of refusal to admit applicant #010, the home failed to take into account the resident's assessments and information and approve the applicant's admission to the home.

Note: the above non-compliance was identified during the inspection of complaint log #017173-16. [s. 44. (7)]

Issued on this 15 day of February 2018 (A3)

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

Original report signed by the inspector.