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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Oct 13, 2015	2015_343585_0019	H-002924-15	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WILLOWGROVE
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

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): September 29, 30, October 1, 2, 6, 7 and 8, 2015.

Concurrent to the Resident Quality Inspection (RQI), eight Critical Incident System inspections (Log #'s: H-001217-14, H-001837-15, H-002322-15, H-002426-15, H-002408-15, H-002617-15, H-002873-15 and H-003322-15) as well as two Complaint inspections (Log #'s: H-003074-15 and H-003230-15) were conducted.

During the course of the inspection, the inspector(s) spoke with residents, families, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Registered Dietitian, a Cook, Dietary Aides, the Support Services Manager, Social Worker, recreation staff, housekeeping staff, Business Manager, Environmental Supervisor, Directors of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, conducted observations of care and services provided to residents, reviewed records including but not limited to clinical health records, policies and procedures, council and committee meeting minutes, staff files, menus, as well as complaint and critical incident records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy, "Resident Falls, LTC-CA-WQ-200-07-08", last reviewed November 2014, directed staff to complete a Post Fall Analysis in Point Click Care (PCC), Morse Risk Assessment, Risk Management, and occurrence note after a resident who was low risk for falls had a fall.

In August 2015, resident #63 was identified as a low risk for falls. In September 2015, the resident had a fall which resulted in an injury and transfer to hospital. Review of the resident's plan of care did not include a Post Fall Analysis in PCC. Interview with the DOC confirmed that a Post Fall Analysis should have been completed and staff did not comply with the home's Resident Falls Policy. (528)

B) The home's policy, "Narcotic and Controlled Substances Administration Record, 04-07 -10", last reviewed June 2014, stated that a daily count of all narcotics can be documented on the Narcotic and Controlled Substance Administration Record; a check of the balance-on-hand must be done by two nurses or care providers at the time of every shift change; and the count and signature are recorded in the appropriate column on the Narcotic and Controlled Substance Administration Record.

On January 9, 2015, a card containing 11 tablets of a narcotic for resident #67 was noted to be missing by registered staff. Review of the resident's plan of care identified they regularly received the narcotic pain medication with additional pain medication on an as needed basis. The resident received additional pain medication on January 6, 2015, at which time, staff noted there to be 11 tablets left in the narcotic card. Review of the Narcotic and Controlled Substance Administration Record, documented 11 tablets of the narcotic, signed by two registered staff. On January 9, 2015 at the end of day shift, registered staff reported the card containing 11 tablets of the narcotic was missing. Interview with registered staff identified that replacement narcotics were received the evening prior to the missing narcotics, at the time, staff confirmed the card was there; and at the end of their shift they counted the narcotics alone. Review of investigation notes confirmed the night RPN was not part of the count on the evening of January 8, 2015, and could not confirm if the missing card was present. Interview with the DOC confirmed that the staff, who counted on January 8, 2105, did not complete the Narcotic and Controlled Substance Administration Record count with two registered staff as required in the home's policy.

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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed to meet the needs of residents with responsive behaviours.

In January 2015, the Minimum Data Set (MDS) Assessment for resident #20 identified they had deteriorated in relation to mood, demonstrating behaviours five out of seven days a week. From November 2014 to March 2015, Point of Care (POC) electronic records included two to eleven documented episodes each month of the behaviours. A progress note from March 2015 described the resident demonstrating the behaviour 30 times over the course of one shift. Review of the written plan of care did not include the behaviour or any interventions for staff to respond to the behaviour until the end of April 2015, at which time, Behavioural Supports Ontario (BSO) became involved. Interview with a Personal Support Worker (PSW) and registered staff confirmed that the resident had ongoing behaviours since admission in 2010, but written strategies to respond to the behaviour were not included in their plan of care until April 2015.

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

The plan of care for resident #61 identified that they demonstrated responsive behaviours. Interventions to assist the resident directed staff to try and talk to the resident for a few minutes first and then ask their permission to complete care, and if resistive, inform registered staff so their pain could be assessed. The resident was receiving regularly scheduled medications for pain and had additional medication if needed, as well as a medication for behaviours and mood. Review of investigation notes identified that on an unspecified date in May 2015, the resident was yelling out to get out of bed. Registered staff requested that PSW staff transfer the resident out of bed. Two staff entered the room to transfer the resident, but the resident was demonstrating responsive behaviours to staff and expressing discomfort. The registered staff remained outside the room during the transfer. Review of the electronic medication administration record (eMAR) revealed that no additional pain medication was provided to the resident. Interview with direct care staff confirmed that the resident was demonstrating responsive behaviours, however staff provided care to due to the risk of falling during transfer; while the RPN was administering medications in the hallway. Interview with the RPN revealed that they were aware the resident was demonstrating behaviours, overheard the resident express discomfort and that no additional pain assessment or pain medications were provided while they were responsive. The RPN could not recall the exact time routine

pain medications were provided but that they were provided prior to the incident. Interview with the DOC confirmed that the strategies developed for resident #61, related to their behaviours were not implemented by PSW or registered staff on the unspecified day in May 2015.

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 ensuring that strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On an unspecified day in September 2015, two residents receiving total assistance were observed seated in unsafe positions during a lunch meal:

i) Resident #80's head was observed hyperextended while in a reclined position in their tilted chair, receiving total assistance from staff. Their plan of care stated they had issues with swallowing. Registered staff confirmed the resident had difficulty swallowing and was not positioned in a safe manner.

ii) Resident #81's head and torso were observed in a reclined position in their tilted chair, receiving total assistance from staff. Their plan of care stated they were at risk for choking and staff were to ensure they were seated upright during meals. A PSW assisting the resident confirmed they were not positioned upright. Registered staff confirmed the resident had issues with swallowing and was not positioned in a safe manner.

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 ensuring that dining and snack service includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Review of a critical incident report identified that on an unspecified date in 2015, two PSWs reported to registered staff that a co-worker made verbally inappropriate comments and was aggressive to residents. As a result of the allegations, the PSW was sent home and an investigation was conducted relating to allegations of abuse to resident #64, #65 and #66. Review of the home's investigation notes and the residents' records did not include documentation that the SDMs of each resident were notified of the allegations. On October 7, 2015, interview with the DOC confirmed the SDMs for the three resident's had not yet been notified of the allegations, investigation and results of the investigation.

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 ensuring that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, 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 failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

A) On September 29, 2015 at approximately 1230 hours, a medication cart outside of the dining room on Battlefield was noted to be unlocked and unattended. An RPN was observed administering medications in the dining room with their back to the cart. The Long-Term Care Homes (LTCH) Inspector was able to open and close medication drawers without the RPN being aware. At the same time, two residents were observed in the hallway approaching the dining room. When the RPN returned to the cart, they confirmed that the cart should have been secured and locked when unattended.

B) On September 30, 2015, at approximately 0945 hours, a medication cart in a Bayfront hallway was noted to be unlocked and unattended. An RPN was observed administering medication to a resident down the hall with their back to the cart. The LTCH Inspector was able to open and close the drawers without the RPN being aware. At the same time, one resident and one visitor were noted in close proximity to the cart. The RPN confirmed the cart was unlocked and should have been secured and locked when unattended.

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 ensuring that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #6: 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 has 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.

The plan of care for resident #15 identified that they had an area of ongoing skin breakdown. In April 2015, the resident's treatment orders changed. Review of the electronic treatment administration record (eTAR) from May and June 2015 did not include documentation that treatment was completed on 13 days in May and June 2015. Interview with registered staff revealed that treatments were completed as ordered; however, were not documented on the eTARS.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

In October 2015, resident #10 reported in an interview that their personal aide had been missing since an unspecified date in September 2015 and did not recall the aide ever being labelled. The following day, the resident was observed with their aide, stating it was found the day before and confirmed it was unlabelled. A regular PSW familiar with the resident was unable to confirm if the aide was ever labelled. A DOC confirmed the home had a policy related to the labelling of aides, and it had not been implemented for resident #10.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

A) On September 29 and October 2, 2015, one of resident #12's personal assistance services device (PASD) was observed with surfaces visibly unclean, coated in dry white debris. On October 2, 2015, another PASD belonging to resident #12 was noted unclean with white debris present. Review of the home's schedule for the cleaning of the PASDs indicated their items were scheduled for cleaning on October 1, 2015. On October 2, 2015, a PSW observed and confirmed the PASDs were unclean and documentation for their cleaning was incomplete. A DOC confirmed the home did not follow their procedures for the cleaning of PASDs.

B) On September 29 and October 2, 2015, resident #20's PASD was observed with white staining and dry debris on the surface and also covered with white dried fluid on the frame. Review of the home's schedule for the cleaning of PASDs indicated the item was scheduled for cleaning on October 1, 2015. On October 2, 2015, a PSW and Administrator confirmed the PASD was unclean despite documentation stating it was completed and the home did not follow their procedures for the cleaning of PASDs.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

The home's missing personal clothing procedure, "Personal Clothing - Missing: ALL-CA-ALL-500-10-02", last revised February 2015, stated the procedure included an initial search of the items. The person reporting the lost clothing will be directed to the lost and found clothing area. The person receiving the report of lost clothing will document all information on the Missing Clothing Report Form. An immediate search of the home area will be completed and results documented on the form. If the item is not found the Environmental Services Supervisor (ESM) will be contacted to initiate search in laundry service area. If not found, the Missing Clothing Report Form will be posted in laundry for three consecutive days. Upon completion of the posting the ESM will contact the person reporting the missing items and report results of the search.

In August 2015, the family of resident #13 reported a number of missing clothing items. Review of the plan of care included a progress note describing the families concerns and that the DOC would be notified; however, did not include a Missing Clothing Report Form. Interview with a RPN and two PSWs confirmed that they were aware of the missing items, that a search was conducted, but the items were still missing. Interview with the RPN confirmed the Missing Clothing Report Form had not been completed as outlined in the home's procedure and was unable to confirm if the resident's family had been contacted with the results of the search.

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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint.

In September 2014, a verbal complaint was made by resident #10 to a recreation staff regarding their personal aide. The staff reported in an interview that the resident told them approximately one week prior that their personal aide was missing, however they did not report or investigate the concern as the resident informed them that other staff were already aware. A review of the resident's clinical record did not include documentation of staff being aware of the missing aide. Multiple registered nursing staff and PSWs stated they were unaware the resident's personal aide was missing. Interview with a DOC confirmed there was no documentation in the resident's clinical record or home's complaints log of the missing aide and a complaint of such matter should have been logged and investigated.

Issued on this 19th day of October, 2015

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

Original report signed by the inspector.