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 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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 30, 2019 | 2018_787640_0028 | 027842-16, 015955-17, 001325-18, 003521-18, 006722-18, 012215-18, 018048-18, 027972-18, 030172-18, 031443-18 | Critical Incident System |

### Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

St. Andrew's Terrace Long Term Care Community
255 St. Andrew's Street CAMBRIDGE ON N1S 1P1

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

HEATHER PRESTON (640)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 17, 18, 19, 20, 21, 27 and 28, 2018 and January 2, 3, 4, 7 and 8, 2019.**

**his inspection was conducted in conjunction with Complaint inspection #2018_787640_0027. LTCH Inspector #735 was on site January 2, 3 and 4, 2019.**
**The following Critical Incident (CI) reports were included in the inspection;**
**Log #015955-17 related to plan of care**
**Log #030172-18 related to responsive behaviours**
**Log #027972-18 related to responsive behaviours**
**Log #006722-18 related to responsive behaviours**
**Log #018048-18 related to responsive behaviours**
**Log #027842-16 related to responsive behaviours**
**Log #012215-18 related to fall with injury**
**Log #001325-18 related to fall with injury**
**Log #003521-18 related to fall with injury**
**Log #031443-18 related to fall with injury**

**PLEASE NOTE: Written Notification and Compliance Order related to O. Reg. 79/10, s. 8 (1) and s. 50 (2) (b) (iii) were identified in this inspection and has been issued in a concurrent inspection report #2018_787640_0027.**

**During the course of the inspection, the Inspector toured the home, observed the provision of care, reviewed clinical records, policy and procedure and conducted interviews.**

**During the course of the inspection, the inspector(s) spoke with residents, family, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Manager of Food Services (MFS), Registered Dietitian (RD), Resident Care Coordinators (RCC),**
**Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Behaviour Support Ontario (BSO) staff, Resident Care Coordinator - Quality and Education, Manager of Environmental Services (MES), Manager of Resident Care (MRC) and the Administrator.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 33. PASDs that limit or inhibit movement**

**Specifically failed to comply with the following:**

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:**
**1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).**
**3. The use of the PASD has been approved by,**
**i. a physician,**
**ii. a registered nurse,**
**iii. a registered practical nurse,**
**iv. a member of the College of Occupational Therapists of Ontario,**
**v. a member of the College of Physiotherapists of Ontario, or**
**vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).**
**4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).**
**5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #009 sustained an injury as a result of a fall that occurred in June 2018.

The resident was observed by the Long-Term Care Homes (LTCH) Inspector to be using a PASD while out of bed.

PSW #110 and RPN #109 told the LTCH Inspector the PASD was used as a safety device to prevent further falls and for positioning and comfort.

The LTCH Inspector reviewed the resident's clinical record which identified in the progress notes that the physiotherapist had recommended the use of the PASD on an identified date in June 2018, and the PASD was implemented that date. The resident's plan of care did not include the use of the PASD.

The Manager of Resident Care (MRC) acknowledged the use of the PASD for resident #009 was not included in the resident's plan of care.

The licensee failed to ensure that the use of the PASD for resident #009 was included in the resident's plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine of activity of living.

Resident #010 was observed by the LTCH Inspector to be using two PASDs.

PSW #113 told the LTCH Inspector the resident used one of the PASDs to assist with bed mobility. The second PASD was being used for safety and comfort.

The clinical record was reviewed and the two PASDs were last consented to be implemented in February 2018. The second page of the form consisted of the list of alternatives to PASDs to trial prior to implementation of any PASD. The form was reviewed and there were no items marked as trialed and there was no date and signature on the back of the form beside the "Alternative to PASD completed".

The MRC acknowledged alternatives to the use of the two PASDs were not completed prior to the implementation of the PASDs.

The licensee failed to ensure that alternatives to PASDs were trialed prior to implementing PASDs for resident #010. [s. 33. (4) 1.]

3. The licensee failed to ensure that the use of a PASD was consented to by the resident's substitute decision-maker (SDM).

Resident #009 sustained an injury as a result of a fall that occurred in June 2018.

The resident was observed by the Long-Term Care Homes (LTCH) Inspector to be using a PASD while out of bed. While in bed, specific PASDs were in place.

RPN #009 told the LTCH Inspector the use of the PASDs in bed were to assist with turning and repositioning and for safety of the resident. The second PASD was used as a safety device to prevent further falls and for positioning and comfort.

The LTCH Inspector reviewed the resident's clinical record and there were no consents authorizing the use of either PASD.

The MRC acknowledged that both PASDs required consent from resident #009's SDM prior to implementation and the home had not obtained consent.

The licensee failed to ensure that consent was obtained prior to the implementation of the two PASDs for resident #009. [s. 33. (4) 4.]

***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 ensure that alternatives to the use of a PASD are considered, and tried where appropriate, but would not be effective to assist the resident with the routine of activity of living, to be implemented voluntarily.***

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**WN #2: 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 a medication cart that was secured and locked.

a) On an identified date in December 2018, the LTCH Inspector observed RPN #119 assisting in the dining room with their back to the medication cart and had left their medication cart unattended. The medication cart was unlocked.

b) On a second identified date in December 2018, RPN #121 was observed to be in a resident room assisting them in their washroom. The medication cart was left in the hallway unattended and the medication cart was unlocked. Two residents were observed wandering in the hallway past and near the unlocked medication cart.

RPNs #119 and #121 told the LTCH Inspector the cart was expected to be locked when left unattended.

The RPNs acknowledged the medication cart was not secured and locked. [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 are stored in a medication cart that is secure and locked, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that training was provided to all staff who provided direct care to residents and applied PASDs or monitored residents with PASDs, training in the application, use and potential dangers of the PASDs.

The LTCH Inspector observed resident #009 to be using a specific PASD positioning device in January 2019. Resident #009 began to move and the LTCH Inspector observed PSW #110 alter the positioning device further. At this time, the LTCH Inspector was interviewing PSW #110 who observed resident #009 move again. The PSW altered the resident's positioning device further.

The PSW told the LTCH Inspector that the amount the PASD positioning device was to be altered was based on the individual PSW's determination and what they believed it should be at the time. They had not received any training related to the use of the PASD positioning device and how to use the positioning device was not included in the resident's plan of care.

The MRC reviewed the training related to the specific positioning device as a PASD. The MRC acknowledged that the application, use and potential dangers when using any PASD was not included as part of the home's PASD training.

The licensee failed to ensure that PASD training included the training, use and potential dangers of using PASDs. [s. 221. (1) 6.]

***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 training is provided to all staff who provide direct care to residents and apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every resident had his or her personal health information within the meaning of the Personal Health Information Act, 2004 kept confidential.

a) On an identified date in December 2018, the LTCH Inspector observed RPN #100's medication cart in the hallway outside of the dining room unattended. The Medication Administration Record (eMAR) was open on the computer screen and personal health information (PHI) related to a particular resident was available to be read by anyone in the area. On top of the medication cart were notes kept by the RPN related to the care and condition of certain residents. There were contractors and a security guard working in the area.

b) On an identified date in December 2018, RPN #119 had left their medication cart in the hallway outside of the dining room as they assisted residents in the dining room. The eMAR screen was open on the computer screen and PHI related to a particular resident was available to be read by anyone in the area.

c) On an identified date in December 2018, RPN #120 was assisting in the dining room. They left their medication cart in the hallway outside the dining room with the eMAR screen open and PHI related to a particular resident was available to be read by anyone in the area.

d) On an identified date in December 2018, RPN #121 was in a resident room assisting a resident in their washroom. Their medication cart was left in the hallway with the eMAR screen open and PHI related to a particular resident was available to be read by anyone in the area. There were residents wandering in the hallway around and near the medication cart.

RPN's #100, #119, #120 and #121 acknowledged the eMAR was available to be read by anyone and the resident's PHI was not kept confidential. [s. 3. (1) 11. iv.]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, including altered skin integrity.

Resident #009 fell and sustained an injury requiring a higher level of care. They returned to the home on an identified date in June 2018, with several areas of altered skin integrity.

The LTCH Inspector reviewed the clinical record and the resident's plan of care which did not include the altered skin integrity related to the injuries.

RPN #109 acknowledged that resident #009's altered skin integrity had not been included in their plan of care.

The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of their skin condition. [s. 26. (3) 15.]

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**Issued on this 4th day of February, 2019**

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

**Original report signed by the inspector.**