Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 1, 2019	2019_821640_0028	017421-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 23 and 24, 2019.

During the course of the inspection, the LTCH Inspector toured the home, observed the provision of care, interviewed residents, family and staff, reviewed clinical records and policy and procedure.

During the inspection, the following Complaint intakes were reviewed:

Log# 017421-19 related to concern about refusal to accept resident back from hospital, weight loss and oral care.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitian (RD), Resident Care Coordinator (RCC), LHIN Coordinator, Acting Manager of Resident Care (AMRC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Légende 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. 53. Responsive behaviours

Specifically failed to comply with the following:

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 has failed to ensure that, for each resident demonstrating responsive behaviours, that interventions and the resident's responses to those interventions were documented.

On an identified date, resident #001 had a significant change in condition wherein they had physically aggressive responsive behaviour.

RPN #105 and #108 were directly involved and intervened physically. RN #102 was the nurse in charge and had responded to the incident. The Acting Manager of Resident Care (AMRC) responded to the incident.

The Long-Term Care Homes (LTCH) Inspector reviewed the progress notes in the clinical record and found one note written by RN #102 did not include interventions implemented or the resident's responses to the interventions.

The licensee's policy "Responsive Behaviour Program", with a revised date of May 27, 2019, directed that the registered team member (RTM), was to complete a clinical assessment when a responsive behaviour occurred and document, at a minimum, who was involved, what events lead up to the incident, what precipitated the incident, if any similar incidents in the past had occurred. If a sudden change in behaviour was identified, the RN was to document, in PCC, all assessments, interventions and follow up that was completed.

The licensee's policy "Resident Chart-Documentation in PCC Progress Notes", policy

#RCM 09-01, with a revised date of March 4, 2019, directed that all significant information about each resident was to be documented in their record. Guidelines for documentation (adapted from Nursing Documentation, College of Nurses of Ontario) included that staff were to document the event, action or assessment in an accurate, true and honest manner, document clearly and concisely. Evaluation of interventions and outcomes to be documented in the progress notes. Document only your own observations and actions. Document all incidents involving a resident in the health care record.

The College of Nurses of Ontario (CNO), Documentation Practice Standard – revised 2008 stated that a nurse met the standard by ensuring that documentation was a complete record of nursing care provided and reflected all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation.

RPN #105 and #108 said they did not document the incident, the interventions implemented or the resident's response to those interventions and their involvement in the incident in the clinical record. RPN #105 said that the RN said they would document the incident on their behalf.

RN #102 said they had not documented the entire incident and their involvement in the clinical record. They had not documented the interventions implemented or the resident's response to those interventions. The progress notes did not indicate any of the other staff who were involved and who they were documenting for.

The AMRC said they had not documented the incident, the interventions or the resident's responses to the interventions or their involvement in the clinical record.

The licensee failed to ensure that the interventions and responses to those interventions were documented for resident #001. [s. 53. (4) (c)]

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 the licensee must ensure that, for each resident demonstrating responsive behaviours, the interventions and the resident's responses to those interventions are documented, to be implemented voluntarily.

WN #2: 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 resident #001's personal belongings were labeled.

On an identified date in April 2019 resident #001's dentures were reported missing.

Three months later dentures were found in the shower room by staff that were believed to be resident #001's.

RPN#106 said that when staff found dentures on their shift, the dentures were not labeled, and they required the family to confirm if the dentures belonged to resident #001. It was later confirmed by the resident's family that the dentures that had been found did belong to resident #001.

The licensee failed to ensure that resident #001's dentures were labeled. [s. 89. (1) (a) (ii)]

2. The licensee failed to ensure that there was a process to report and locate resident's personal items.

Resident #001's dentures were reported missing.

Three months later, dentures were located in the shower room by staff that were believed to be resident #001's dentures. It was later confirmed by the resident's family.

RPN #108 said they were the lead for lost items. When they became aware that a resident had lost a personal item such as dentures, they personally would look in the resident's room and all over the home area. They asked the team members what may have happened to them and checked with laundry. They speak with staff who had provided care prior to the dentures going missing. The registered staff also checked the medication room and medication cart. They also had dietary check the food trays. They did not recall looking for resident #001's dentures.

PSW #103 said the process for missing dentures was to inform the RPN and document in POC their loss. They would look all over the resident room and their wheelchair if the resident used one. If not located, they would inform the RPN again. The next shift would repeat the search of the resident room and wheelchair. The RPN would inform laundry to look for the dentures.

PSW #100 said the nurse does a progress note under missing items and added it to the communication board in PCC so all departments could see the dentures were missing and would look for them.

PSW #101 said they would tell the nurse and look through all the resident rooms, the other home area on the floor and ask laundry.

The licensee's policy "Enviro 09-26 Lost and Found", with a last review date of June 7, 2019, directed staff on the process related to lost or unidentified personal laundry.

The AMRC said the home did not have a policy related to any other lost or missing personal items including dentures.

The licensee failed to ensure that there was a process to report and locate resident's personal items. [s. 89. (1) (a) (iv)]

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 the licensee must ensure that:
a) resident's personal belongings are labeled and,
b) a process is developed and implemented to report and locate resident's missing personal items, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences

Specifically failed to comply with the following:

s. 138. (1) If the requirements set out in subsection (2) are met, but subject to subsection (3), a licensee of a long-term care home shall ensure that when a long-stay resident of the home returns from a medical absence, psychiatric absence, casual absence, or vacation absence, the resident receives the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence. O. Reg. 79/10, s. 138 (1).

s. 138. (6) A licensee of a long-term care home shall ensure that before a resident of the home leaves for a medical absence or a psychiatric absence,
(a) except in an emergency, a physician or a registered nurse in the extended class attending the resident authorizes the absence in writing; and O. Reg. 79/10, s. 138 (6).

s. 138. (7) A licensee of a long-term care home shall ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence. O. Reg. 79/10, s. 138 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was returned to their home from a medical absence the resident received the same room and the same bed in that room as the resident had before the absence.

On an identified date, resident #001 was transferred out for a medical assessment.

The Local Health Integration Network (LHIN) Coordinator at the hospital said they had notified the home later the same day that the resident had been assessed, diagnosed, had treatment prescribed and was ready to be transferred back to the home and that the AMRC refused to accept the resident back to the home to the same room and bed that the resident had prior to being transferred.

The AMRC said they had consulted with the home's Administrator after they decided to refuse the return of the resident.

The Administrator said they had told the family they would discharge the resident from the home if the home felt they were unable to keep others safe and provide the necessary care to their loved one.

The licensee failed to ensure that resident #001 was returned to their home and the same room and bed they had prior to being transferred. [s. 138. (1)]

2. The licensee failed to ensure that before a specific absence, a physician or a nurse in the extended class attending the resident, authorized the absence in writing.

On an identified date, resident #001 had a significant change in condition wherein they had physically aggressive responsive behaviour. The resident was transferred for medical assessment and had not been returned to the home.

On a second identified date, it was decided during a meeting of hospital staff #109, #110 and #111 and the Administrator and the Acting MRC of the home, that the resident be placed on a specific absence.

The Administrator and hospital staff #109 said the resident's attending physician was not in attendance at the meeting and had not authorized in writing the proposed absence.

Hospital staff #109 said the Administrator of the home had authorized the specific absence after it was suggested by hospital staff.

The licensee failed to ensure that resident #001's specific absence was authorized in writing by their attending physician or nurse in the extended class. [s. 138. (6) (a)]

3. The licensee failed to ensure that when a resident left the home for a medical or psychiatric absence, that information about the resident's drug regime, known allergies, diagnosis and care requirements were provided to the resident's health care provider during their absence.

On an identified date, resident #001 had a significant change in condition wherein they had physically aggressive responsive behaviour. The resident was transferred to the hospital and had not been returned to the home.

On a second identified date, it was decided that the resident be placed on a specific leave.

The progress notes were reviewed by the LTCH Inspector and there were no notes indicating what documents had been sent to the hospital during transfer or at any other time.

RN #102 said they had prepared documentation to send with the resident. They sent the transfer record including the main concern, Advanced Directives, the consent to share information, recent lab work, the medication administration record and the resident's resuscitation preference form.

The AMRC said there was no documentation in the resident's clinical record indicating the information provided to the resident's health care providers related to their current absence.

The licensee failed to ensure that resident #001's care requirements were sent to their health care providers at the hospital. [s. 138. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that residents are returned to their home from a medical absence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's written record was kept up to date at all times.

On an identified date, resident #001 had a significant change in condition wherein they had physically aggressive responsive behaviour. The resident was transferred to the hospital and was subsequently put on a specific leave.

The Administrator said they had discussions with the hospital and the resident's family regarding resident #001. They had kept some notes in various locations in their office. When asked, they had provided a hand-written listing of dates of discussions held. They said they had not documented in the clinical record.

The AMRC said they had kept some notes in various locations in their office and had not documented any interactions with the family and hospital, in the resident's clinical record. They had no process to obtain status updates about the resident.

The LTCH Inspector reviewed the clinical record which did not contain any notes updating the resident's status, discussions held with the hospital and with the resident's family.

The AMRC acknowledged there was no documentation in the clinical record to keep the resident record up to date during their absence.

The licensee failed to ensure that resident #001's clinical record was kept up to date at all times. [s. 231. (b)]

Issued on this 18th day of November, 2019

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

Original report signed by the inspector.