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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 3, 2018	2017_561583_0023	026709-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

TALL PINES LONG TERM CARE CENTRE
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

KELLY HAYES (583), DARIA TRZOS (561), NATASHA JONES (591)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27, 28, 29, 30, and December 1, 2017.

The following Complaint inspections were completed concurrently with this inspection:

Critical Incident Inspections:
Log #004767-17, related to medications.
Log #007182-17, related to alleged staff to resident abuse.
Log #020615-17, related to responsive behaviours.
Log #020776-17, related to falls.
Log #027687-17, related to unsafe transfers.

Complaint Inspection:
Log#016283-17, related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOCs), Program Support Nurse (PSN), Physiotherapist (PT), Activation and Volunteer Supervisor, registered staff, Behavioural Supports Ontario (BSO) staff, personal support workers (PSWs), Residents, substitute decision makers (SDMs) and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **7 WN(s)**
- **4 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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A CIS report was submitted to the Director, related to an altercation between resident #017 and #021 that caused both of them to sustain minor injuries. Clinical health records were reviewed and indicated that resident #021 went into resident #017's room and when staff heard loud yelling and entered the room both residents were demonstrating responsive behaviours. The residents were separated, assessed and closely monitored.

Registered staff #114 was interviewed and indicated that it was an expectation that resident #017 was closely monitored and Direct Observation Study (DOS) charting was completed.

The SOC #003 was interviewed and shared that after such incidents it was expected that the staff initiate DOS monitoring for seven days. The SOC #001 stated that DOS monitoring should be completed for both residents as during this incident the home was not sure of who started the altercation.

The clinical health records were reviewed and no DOS monitoring could not be found for both residents.

The policy titled "Prevention and Management of Responsive Behaviour Program", revised May 5, 2014, indicated that the role of the registered staff was to screen residents when there is a change of status that affects behaviour and initiated DOS on the electronic health record for seven days.

The licensee failed to ensure that when residents #017 and #021 were harmed as a result of the residents' behaviours an intervention of DOS monitoring was not implemented to assist residents to minimize the risk of further altercations and potentially harmful interactions.

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Long-Term Care Homes (LTCH) Inspector #591, while conducting an initial tour of the home, observed that the spa door on a specified unit was left ajar. Inside the spa room, resident #029 was observed sitting without clothing in an Alenti bath chair lift, raised above the tub. The resident had a bath sling on, and the seat belt on the bath chair was not fastened. The resident was alone and unsupervised in the spa room. In the corridor, PSW #113 was observed at the computer documenting. The PSW could not see the resident in the spa room from their position in the corridor.

A review of the home's document titled "Manual Material Handling and Minimal Lift Training - 2017" indicated that the safety belt must be used with the Alenti bath chair for safety. A review of the home's document titled "Alenti model #CDB81XX- Arjo Huntleigh manufacturer's instructions" indicated the safety belt was indicated for resident use, and pictures in the diagrams provided visual direction on how to apply and secure the safety belt.

In an interview, PSW #113 confirmed the resident should not have been left unattended in the spa room, and the safety belt on the Alenti bath chair should have been fastened around the resident.

In an interview, SOC #1 indicated that PSW #113 should have ensured the safety belt was fastened to resident #029 while they were in the Alenti bath chair, as per the manufacturer's instructions and as per the home's training materials. The home failed to ensure staff used the Alenti bath chair in accordance with manufacturers' instructions. [s. 23.]

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 all equipment in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) A Critical Incident System (CIS) report was submitted to the Director, related to alleged staff to resident #025 abuse resulting in minor injury.

Investigation notes were reviewed during the inspection and revealed that staff to resident abuse was not confirmed; however during the demonstration of how the injury occurred the home identified that the PSW #114 used an unsafe transfer technique.

LTCH Inspector #561 was not able to interview the PSW. Interview with the Administrator confirmed that during the provision of care, with the assistance of a PSW, the resident became unsteady and sustained an injury.
The home failed to ensure that staff in the home used a safe technique.

This area of non-compliance was identified during a CIS Inspection conducted concurrently during the RQI Inspection.

B) LTCH Inspector #591, while conducting an initial tour of the home observed that the spa door on an identified unit was left ajar. Inside the spa room, resident #029 was observed sitting without clothing in an Alenti bath chair lift, raised above the tub. The resident had a bath sling on, and the seat belt on the bath chair was not fastened. The resident was alone and unsupervised in the spa room. In the corridor, PSW #113 was observed sitting at the computer documenting. The PSW could not see the resident in the spa room from their position in the corridor.

A review of the home's policy titled "Minimal Lift Program", revised March 2011, indicated "bath chair lifts will be used in conjunction with the bathtubs and showers; two caregivers must be present when transferring a resident on to the bath chair/commode if the resident is to be transferred using the total lift"; "it is mandatory that two staffs are present

when using the mechanical lift, one to operate the lift and the other to guide the resident".

In an interview, PSW #113 they confirmed the resident should not have been left unattended in the spa room.

In an interview, registered staff #117 indicated that the bath chair lift was used to transfer the resident for bathing, and resident #029 should not be left unattended in the spa related to their cognitive impairment.

In an interview, SOC #1 indicated that PSW #113 should not have left resident #029 unsupervised in the spa room. The home failed to ensure staff used safe transferring techniques when positioning and transferring resident #029.

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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

Resident #019 had a plan of care indicating that they had an area of altered skin integrity. Clinical records were reviewed and the weekly skin assessments were not always completed for this resident. The Point Click Care (PCC) records indicated that skin assessments were not completed on three dates over a three month time period in 2017. The Registered staff #115 was interviewed and stated that it was an expectation that weekly skin assessments were completed for residents with altered skin integrity and that this resident did not have them completed on three dates.

The home's "Skin and wound program", revised June 27, 2016, indicated that wound assessments must be completed on weekly basis on PCC. The SOC #001 confirmed that wound assessments were expected to be completed on weekly basis. The home failed to ensure that resident's wound was reassessed weekly by registered staff. [s. 50. (2) (b) (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 to ensure residents exhibiting altered skin integrity, including pressure ulcers are assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for each resident that set out, (a) the planned care for the resident.

Resident #010 was observed and it was identified that they had two Personal Assistance Services Device (PASDs). During an interview with resident #010 they shared that one PASD was in use and that the other was not being used as it would inhibit their ability to move independently throughout the home.

A review of the resident #010's current written plan of care, did not include the use of

either PASD. This was confirmed by registered staff #109 in an interview.

In interviews with SOC #1 and the Physiotherapist (PT), they confirmed that an assessment was completed by the PT, who made recommendations related to the PASDs however, the resident's written plan of care was not updated to identify the planned care of the resident.

The home did not ensure the personal assistance services device's used by resident #010 were included in their written plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out, (c) clear direction to staff and others who provided direct care to the resident.

Resident #011 had a written plan of care indicating they were on the incontinent check and change program and required one person extensive assistance for toileting.

In an interview with PSW #101 and registered staff #100 they indicated resident #011 required varying levels of assistance with toileting depending on the time of day. It was shared they were sometimes a one person transfer and sometimes at two person with a mechanical lift. This was not identified in the plan of care and the registered staff confirmed that the written plan of care did not provide clear direction to staff in relation to toileting.

The home failed to ensure that the written plan of care set out clear direction to staff in relation to continence care for resident #011. [s. 6. (1) (c)]

3. The licensee failed to ensure that the resident who was reassessed, their plan of care was reviewed and revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #016 had a written plan of care and the kardex indicating that they were incontinent and required two person extensive assistance for toileting.

The interview with PSW #102 and registered staff #100 indicated that resident #016 required assistance from one staff for toileting. Resident #016 was observed during the inspection and did not have any signs of incontinence and was observed mobilizing independently.

Registered staff #100 confirmed resident #016 had a change in continence and currently required only one person assistance for toileting. They confirmed that the care plan was not revised to address the change from the previous assessment, which indicated that resident required two person assistance.

The licensee failed to ensure that the plan of care was reviewed and revised when there was a change in resident's level of assistance for toileting. [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that within 10 days of receiving the advice, that they responded to the Residents' Council in writing.

In an interview, resident #035 who was a member of the Residents' Council, indicated that they were responsible for signing the meeting minutes and confirmed they did not have a Council President at present. They further indicated that the Council did not receive a written response to their concerns; however, a verbal response was usually provided.

A review of the home's Residents' Council Binder, revealed that concerns were raised by the Council on September 13, 2017, a concern was raised regarding the hot water in the home; on November 8, 2017, a concern was raised regarding a family member who brought a dog into the dining room; and on November 8, 2017, a concern was raised regarding a towel warmer not working in the tub room. There was no evidence that a written response had been provided for the above mentioned concerns.

In an interview with the Activation and Volunteer Supervisor, they confirmed that concerns raised by the Residents' Council were responded to verbally; however, a written response was not provided.

The home did not ensure a written response was provided to the Residents' Council within ten days of receiving a concern. [s. 57. (2)]

WN #7: 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 has fail to 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

Observation of the vaccine fridge on November 29, 2017, revealed the fridge was stored in the Program Support Nurses (PSN) office. A review of the home's Vaccine Temperature Logbook indicated the fridge was checked during the week, but not on weekends, which included Saturdays and Sundays, from January 2017 to present.

In interviews, the DOC and PSN indicated the fridge was only checked twice daily during the week by the PSN, who was the only one with access to the office where the fridge was stored. The PSN did not work on weekends, therefore the fridge was not checked. The PSN further stated that the Peel Public Health Nurse had conducted their annual inspection in March, 2017, and were aware that the fridge was not checked on the weekends.

In an interview with the Peel Public Health nurse responsible for the last vaccine fridge inspection in the home in March 2017, they indicated that the vaccine fridge was stored in a locked office that staff on the weekends did not have access to, therefore the home did not check the fridge on the weekends. The nurse confirmed that the home is open 24 hours, and has registered staff that could be given access and trained to check the fridge to ensure it was checked twice daily as per Public Health and Best Practice guidelines. The Public Health Nurse confirmed the vaccine fridge should be checked twice daily.

A review of the home's policy #LTC8-06.01, titled "Vaccine Storage, Handling and Management", effective April 5, 2011, indicated that the vaccine refrigerator must be monitored at least twice daily, 365 days per year; and, the temperature must be recorded in the Temperature Logbook twice daily.

A review of the Peel Public Health "Vaccine Storage and Handling Guidelines" indicated the above as well. The home did not ensure vaccines were stored in a manner that complied with the Public Health Best Practice Guidelines. [s. 129. (1) (a)]

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Issued on this 17th day of January, 2018

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

Original report signed by the inspector.