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

Division de la responsabilisation et de la performance du système de santé
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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
May 11, 2015	2015_306510_0006	H-002194-15	Resident Quality Inspection

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET DUNNVILLE ON N1A 2P7

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

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST DUNNVILLE ON N1A 1T3

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

IRENE SCHMIDT (510a), CAROL POLCZ (156), ROBIN MACKIE (511)

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): March 24, 25, 26, 27, 30, 31, 2015 and April 1, 2, 7, 8, 9, 10, 2015

Critical Incident Inspections for H-001351-14 and H-02033-15 were inspected during this RQI. Findings of non-compliance related to H-02033-14 are contained in this inspection report. As well, follow up was completed on H-001783-14 and H-001782-14.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (A/DOC), RAI Coordinator, Director Therapeutic Recreation and Volunteer Services, Environmental and Food Services Manager (EFSM), Business Services Manager, staffing/scheduling clerk, registered nursing staff, personal support workers,dietary staff, housekeeping staff, family members and residents. During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas and reviewed relevant documents including but not limited to: policies and procedures, meeting minutes, menus and clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **22 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 221. (1)	CO #001	2014_306510_0021	510a
LTCHA, 2007 S.O. 2007, c.8 s. 31. (2)	CO #002	2014_306510_0021	510a

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. s. 8. (3)

The home provides services to 64 residents. Review of the home's registered nurse (RN) staffing schedules revealed that during an identified time frame there were several unfilled RN shifts. The staffing coordinator confirmed that when unable to fill an RN shift, a registered practical nurse (RPN) is identified to be in charge. This was confirmed by the A/DOC. The licensee did not ensure a registered nurse was on duty and present at all times. [s. 8. (3)]

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 there is at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, on duty and present in the home at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises, to minimize risk to the resident. O. Reg. 79/10, s. 15 (1).

On an identified date, three residents were observed to have bed rails in the up position. Review of the residents' charts revealed the absence of resident specific assessments related to entrapment, for bed rails. The RAI coordinator and the A/DOC confirmed that resident specific assessments for entrapment related to bed rails, had not been completed. [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practises, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and that it is complied with. s. 20. (1)

The home's policy #N-16-30 titled 'Critical Incident/Mandatory Reporting and Disclosure' and dated 2010/11/29, directed that "a person who has reasonable grounds to suspect that any of the following occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
4. Misuse or misappropriation of a resident's money"
On a specified date, an identified resident advised an inspector that they believed an identified person, was misappropriating their funds. The A/DOC was advised of this allegation on an identified date. The critical incident (CI) report to the Ministry was provided on a future identified date. The A/DOC confirmed the allegation was not reported immediately, as required by policy. [s. 20. (1)]

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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents and that it is complied with, 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 (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 was specifically designed for skin and wound assessment.

A) An identified resident was observed to have dressings applied to specified areas on an identified date. The resident stated they had pain to the affected area. A review of the eTar revealed the resident had impaired skin integrity that required treatment. Topical treatments were to be applied to specified areas twice a day and dressings applied. The progress notes also indicated the resident had a wound at an identified site on an identified date. There was no evidence that a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed for the resident's identified areas of altered skin integrity. The A/DOC, confirmed the absence of the above evidence.

B) A review of an identified resident's Wound Tool assessment document, on a specified date, indicated they had a described alteration in skin integrity on a specified area of the body. The next Wound Tool assessment was completed on an identified date that described two specific areas of altered skin integrity. A review of the progress notes

indicated the resident also had a dressing to a different specified area. Interview with the RPN on duty stated there were only two wound tool assessments, approximately three months apart and that the resident had another area of altered skin integrity that was not included on either of these assessments. Interview with the A /DOC confirmed the identified resident exhibited altered skin integrity, and had not received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (511) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iii) was 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.

A review of the clinical record for an identified resident indicated they had a specified alteration in skin integrity on an identified date. The most recent registered dietitian (RD) assessment note, on an identified date, was for a change in the resident's weight. Interview with the registered staff on the floor stated a paper copy referral would be completed and sent to EFSM for an RD assessment to be completed. Interview with the EFSM confirmed the paper referral was not completed when the resident was noted to have a specified alteration in skin integrity and the resident had not been assessed by a Registered Dietitian who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

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, for residents exhibiting altered skin integrity:
1) skin assessments, by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment, are completed
2) assessment by a registered dietitian who is a member of the staff of the home, is completed and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #5: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

During stage one Resident Quality Inspection (RQI), identified residents were triggered from minimum data set (MDS) assessments related to low risk incontinence. Review of the clinical records revealed an absence for each resident of a clinically appropriate assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. The RAI coordinator and the A/DOC confirmed that at this time, assessments using a clinically appropriate assessment instrument were not completed. [s. 51. (2) (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 each resident who is incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; (c) identifies measures and strategies to prevent abuse and neglect; (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

The home's policy #06-01-06 titled 'Preventing Resident Abuse' is, as confirmed by the A/DOC, the policy that directs the promotion of zero tolerance of abuse and neglect of residents at the home. The policy does not contain the following components, as required under the Act:
1) procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected
2) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate
3) measures and strategies to prevent abuse and neglect
4) training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations
The above was confirmed by the A/DOC. [s. 96. (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 he licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to, a) assist and support residents who have been abused or neglected or allegedly abused or neglected; (b) deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; (c) identify measures and strategies to prevent abuse and neglect; (e) identify the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

An identified resident's clinical record indicated they were at a high risk for altered skin integrity related to complex clinical diagnoses. The resident's quarterly eMar for an identified time frame described the resident received multiple skin and wound treatments related to altered skin integrity to specified areas. One treatment was a specific order to be completed on the resident's bath days. A review of the eTar for an identified time frame confirmed the specified treatment was administered on these days but not administered after an identified date. A new treatment was added on an identified date to the eTar for this wound to be cleansed and dressed in an identified manner. There was no physician or nurse practitioner order that discontinued the previous order or that prescribed this new treatment. A nursing note indicated the RN on duty had changed the dressing protocol based on their assessment of the wound. Interview with this RN confirmed they had no formal training from the home for skin and wound care, and the home had not provided medical directives or wound care protocols for skin and wound care. The RN provided a 2002 reference as a resource. Interview with the A/DOC confirmed the home's policy was to obtain physician's orders for treatment and dressing of wounds and that the home did not have but was working on developing skin and wound care protocols for the home. The A/DOC confirmed the resident's dressing order was changed and a new dressing order administered without being prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) An identified resident had an identified medical diagnosis and the Medical Administration Record (MAR) indicated the resident received an identified medication, three times a day, based on identified clinical parameters. An order was received from the physician on an identified date to hold the medication if the identified clinical parameters met specified criteria. On two identified occasions, documentation revealed the resident's clinical parameters met the specified criteria for the medication to be held; however, the medication was administered. Interview with the registered staff who administered the medication dose confirmed the order had been changed recently and were unaware the medication was to be held if the specified criteria were met. Interview with the A/DOC confirmed the licensee did not ensure the medication was administered to the resident in accordance with the directions for use specified by the prescriber.

B) A review of the clinical record for an identified resident indicated they had an identified diagnosis and were prescribed an identified medication daily with a specified

clinical assessment prior to administration. A review of the medication administration record (MAR) confirmed the specified clinical assessment to be completed prior to administering the medication. If the clinical assessment met an identified parameter, the medication was to be held. A review of the electronic MAR for the identified resident confirmed that on multiple identified dates the resident was administered the identified medication even though the identified clinical parameters indicated the medication should be held. Medication administration on these identified occasions was inconsistent with the directions for use specified by the prescriber.
Interview with the A/DOC confirmed the licensee did not ensure the medication was administered to the resident in accordance with the directions for use specified by the prescriber. (511) [s. 131. (2)]

3. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On an identified date the RPN was observed to provide the identified resident with their morning medications in a medication cup on their bedside table while the resident was in the washroom. The resident was observed to communicate to the nurse to leave the medications and they would take the medication later by themselves. A review of the MAR indicated that nine identified medications were left at the bedside.
The plan of care indicated staff were to provide the administration of medication as ordered and observe for adverse reactions. Interview with the RPN confirmed there was no order for the self administration of medication by the resident but they would sign that the medication was administered by the nurse. Interview with the A/DOC confirmed the licensee failed to ensure that the identified resident had administered a drug to himself or herself when the administration had not been approved by the prescriber in consultation with the resident. [s. 131. (5)]

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, a) no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, b)drugs are administered to residents in accordance with the directions for use specified by the prescriber, and c) no resident is administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #8: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure, for the purposes of paragraph 6 of subsection 76 (7) of the Act, training was provided to all staff who provide direct care to residents: 2. Skin and wound care.

A review of the clinical record for an identified resident indicated the resident had altered skin integrity on an identified date. The progress note indicated the area of altered skin integrity was treated once in a particular manner. Interview with the RN on duty, on an identified date, indicated they were unaware of an area of altered skin integrity or the treatment required for this resident as there was no eTar created that described a treatment for the area of altered skin integrity. Interview with the RN confirmed the home had not provided training on how to treat different staged wounds and each of the registered staff would use their own experience to determine how to stage and treat a wound and when to refer to the physician. The A/DOC confirmed training for skin and wound care had not been provided to direct care registered staff or front line PSW's. [s. 221. (1) 2.]

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 training in skin and wound care is provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: 4. A record must be maintained by the licensee setting out, i. improvements made to the quality of accommodation, care, services and goods provided to the residents. O. Reg. 79/10, s. 228.

When completing the Licensee Confirmation Checklist for Quality Improvement and Required Programs, the A/DOC reported the home did not maintain a record of the improvements made to the quality of the accommodation, care, services, programs and goods provided to residents, or a record of the persons who participated in evaluations and the dates the improvements were implemented. On an identified date, the A/DOC provided the balanced score card for the home as documentation of quality improvements. The document provided did not include indicators related to the quality of the accommodation, care, services, programs and goods provided to residents. The A/DOC confirmed the home did not maintain a record setting out, i. the improvements

made to the quality of accommodation, care, services, programs and goods provided to the residents. [s. 228. 4. i.]

2. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the following requirements: 4. A record must be maintained by the licensee setting out, ii. the names of the persons who participated in evaluations, and the dates improvements were implemented. O. Reg. 79/10, s. 228.

When completing the Licensee Confirmation Checklist for Quality Improvement and Required Programs, the A/DOC reported the home did not maintain a record of the persons who participated in evaluations and the dates the improvements were implemented. On an identified date the A/DOC provided the balanced score card for the home as documentation of quality improvements. The document provided did not include documentation of the names of the persons who participated in evaluations, and the dates improvements were implemented. The A/DOC confirmed the home does not maintain a record setting out, the names of the persons who participated in evaluations, and the dates improvements were implemented. [s. 228. 4. ii.]

3. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements: 4. A record must be maintained by the licensee setting out, iii. the communications of the improvements made to the quality of the accommodations, care, services, programs and goods provided to residents to the Residents' Council, Family Council and staff of the home on an ongoing basis. O. Reg. 79/10, s. 228.

When completing the Licensee Confirmation Checklist for Quality Improvement and Required Programs, the A/DOC reported the home did not maintain a record of the improvements made to the quality of the accommodation, care, services, programs and goods provided to residents, or a record of the persons who participated in evaluations and the dates the improvements were implemented. On an identified date, the A/DOC provided the balanced score card for the home as documentation of quality improvements. Although this document was shared with Residents' Council, the document did not include indicators related to the quality of the accommodation, care, services, programs and goods provided to residents. The A/DOC confirmed the home did not communicate improvements made to the quality of accommodation, care, services, programs and goods provided to the residents, to Residents' Council or staff of the home. [s. 228. 4. iii.]

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 the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1) A record must be maintained by the licensee setting out, i. improvements made to the quality of accommodation, care, services and goods provided to the residents ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and iii. the communications under paragraph 3, to be implemented voluntarily.

WN #10: 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 has failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has the right to, 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.

An observation of the medication administration process was completed on an identified date. It was observed that the resident medication dispensing pouches, provided by the pharmacy, were disposed of by the RPN in a clear bag located on the side of the medication cart once the medication was administered. The RPN confirmed the clear bag was then discarded in the regular garbage without having the resident's personal health information denatured or removed from the pouch. The information on the pouch contained the resident's name, medication, dose and frequency of drug administration. Interview with the A/DOC confirmed this information was the resident's personal health information, within the meaning of the Personal Health Information Protection Act, and the information was not kept confidential, in accordance with that Act, when it was discarded in the regular garbage disposal system. [s. 3. (1) 11.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 has failed to 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.

A review the MDS assessment for an identified resident on an identified date, section M for their skin condition noted the resident had an alteration in skin integrity. The RAP for the same date, under the resident's activities assessment stated they did not attend morning programs on a regular basis as they are resting in bed after breakfast due to skin breakdown. The RD assessment completed in the resident's Dietary Quarterly Review on an identified date indicated the resident's skin appeared intact, with no skin issues. Interview with the RAI Coordinator confirmed the staff involved in the different aspects of care of the resident had not collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the clinical record for an identified resident indicated that on an identified date they were not feeling well and reported this to a PSW who then reported to the RPN. The RPN assessed the resident, reviewed the care plan and provided an intervention. After an observation period, they left the resident alone in their room. Later on the identified date, the power of attorney (POA) came to the home indicating the resident had called them. A review of the resident's plan of care directed the staff to call the POA when these episodes of not feeling well occurred. A review of the clinical record did not indicate the POA was called as directed by the resident plan of care. Interview with the RN confirmed the direction in the resident's plan of care and indicated the POA should have been called. Interview with the DOC confirmed the licensee had not ensured the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

A) The plan of care for an identified resident stated that the staff were to physically cue the resident to complete an identified activity of daily living (ADL). Interview with front line staff on an identified date reported that the resident was totally dependent on staff for the ADL and the care plan was not current. The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs had changed.

B) A review of the plan of care for an identified resident, as confirmed by the front line staff, was located on the residents chart. The plan of care identified the resident had altered skin integrity and an infection. Interview with the RPN and two PSW's, that provided care to this resident, confirmed on an identified date the resident's altered skin integrity had healed. On an identified date, the Wound Tool assessment indicated the resident had altered skin integrity with signs of infection. Interview with the RAI coordinator confirmed the plan of care was not reviewed and revised when the the resident's care needs changed or care set out in the plan was no longer necessary. (511)

C) On an identified date, during a family interview, it was reported that an identified resident had a safety intervention in place until a few months ago because they were at

high risk of falls and that the intervention had been removed. On an identified date, the care plan was reviewed. It directed that the intervention should be in place at identified times. The resident was observed on that date and found not to have the intervention in place. Interviews with registered staff and personal support staff confirmed that the resident no longer used the intervention. The above was confirmed with the RAI coordinator. The care plan was not updated when the resident's care needs changed. (510) [s. 6. (10) (b)]

WN #12: 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 has failed 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.

The home's document titled 'Resident Information Handbook' identified approved absences as:
* up to 30 days extended medical leave for admission to hospital
* up to 60 days extended psychiatric leave for admission to hospital
* up to 21 days absence is permitted each year for vacation
* up to 48 hours per week permitted for casual leave of absence
The document advised that during these absences, the resident must continue to pay their portion of the payment and that if the resident required leave from the home for these reasons and exceeded the allowable days of absence, bed holding charges would apply. The Business Office Manager and A/DOC confirmed that beds have been held for residents beyond the allowable absence limits.
The home's provision for bed holding beyond the allowable absence is not in compliance with applicable requirements under the Act. [s. 8. (1) (a)]

WN #13: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 4. Vision.

An identified resident's MDS assessment, section D, for an identified date, indicated the resident had a visual impairment with no visual correction. This was further detailed in the Resident Assessment Protocol (RAP) and indicated the resident did not always wear their glasses consistently. The RAP stated the plan of care was current to meet the resident's needs for vision. A review of the most current plan of care did not indicate the resident's impaired vision and the need to wear their glasses. The resident indicated on interview that they liked to wear their glasses to see people. Interview with the RAI coordinator confirmed the plan of care was not based on, at a minimum, the interdisciplinary assessment of the resident's vision needs. [s. 26. (3) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, within six weeks of the admission of the resident, and at least annually after that; (b) the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and (c) a record is kept of the date, the participants, and the results of the conferences.

A) The licensee failed to ensure that an identified resident received an interdisciplinary team conference for an identified time frame. A record of the annual care conference was not found in the resident's clinical record. The Substitute Decision Maker (SDM) of the identified resident reported on an identified date that they were not invited to the annual care conference for the resident. The RAI Coordinator confirmed on an identified date that the resident and their SDM were not invited to participate in the care conference and a record was not kept of the conference because it did not occur for the identified time frame.

B) The licensee failed to ensure that the identified resident received an interdisciplinary team conference for an identified time frame. A six week care conference was found in the resident's clinical record; however, it was completed late at ten weeks after the resident's date of admission. A subsequent care conference for the resident did not occur for the identified time frame.

C) The SDM of an identified resident reported that they were not invited to the annual care conference for the resident. The RAI Coordinator confirmed on an identified date that the identified resident and their SDM were not invited to participate in the care conference and a record was not kept of the conference because it did not occur for 2014. [s. 27. (1)]

WN #15: 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.

A review of the identified resident's clinical record indicated the resident experienced moderate pain daily and required pharmacological and non pharmacological interventions to address their pain. A review of the eMar for an identified time period confirmed the resident received pain meds orally for pain but would occasionally refuse their pain medication as they didn't like to take pills. Interview with the PSW and RPN, that provided care to this resident, confirmed they would provide non pharmacologic interventions to help with controlling the pain daily but stated they didn't always document this intervention or the resident's response. A review of the clinical record confirmed the non pharmacologic interventions and the resident's responses to these interventions were not documented. Interview with the A/DOC confirmed the licensee did not ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (2) The agreement referred to in paragraphs 2 and 3 of subsection (1) must be a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf. 2007, c. 8, s. 91 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident shall not be charged for anything, except in accordance with the following: 3) For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provide for, more than a reasonable amount. (2) The licensee failed to ensure the agreement referred to in paragraphs 3 of subsection (1) must be a written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf.

A review of an identified resident's plan of care indicated the resident attended a private, specialized foot care clinic. A review of the Edgewater Trust Account-Audit report for an identified time frame indicated payment was deducted from the resident's trust account on an identified date. A review of the nursing progress notes for an identified date stated " routine foot care provided" by the home's contracted Foot Care Specialist. Interview with the home's business manager confirmed there was no written agreement with the resident or a person authorized to enter into such an agreement on the resident's behalf for the on site services provided on an identified date by the Foot Care specialist for routine foot care. Interview with the A/DOC confirmed 73% of the residents were receiving foot care from the home's foot care specialist and there were no written agreements with the resident or a person authorized to enter into such an agreement on the resident's behalf for the on-site services provided by the Foot Care specialist for foot care. [s. 91. (2)]

WN #17: 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 has failed to 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 was 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 alleged harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Interview with a family member of an identified resident indicated they were unhappy with the care provided to the resident on an identified date which resulted in them coming to the home and taking the resident home on a leave of absence (LOA). The family member stated they felt there should have been more staff to provide care to the resident. A review of the progress notes confirmed the family member made a verbal complaint to the RPN on duty the night of the incident and called the home on an identified date to further complain of the care provided on an identified date to the RN. The RN progress note indicated the family member was not happy and made a number of 'dissatisfied' remarks to the RN and asked for the DOC. The family member was told the DOC was not in and the family member confirmed, that the DOC had not followed up with her on their concerns since the incident. Interview with the A/DOC confirmed the licensee failed to ensure the verbal complaint of an identified date, made to the staff member concerning the care of the identified resident and operation of the home was investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint. [s. 101. (1) 1.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

The A/DOC confirmed that:
* on an identified date, Public Health declared a disease outbreak of Influenza A at the home
* on an identified date, a critical incident report was submitted to the director
* on an identified date, the disease outbreak was declared over
An outbreak of a reportable disease was not immediately reported. [s. 107. (1) 5.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The identified resident's MDS documentation review for an identified period of time indicated an increase in their pain level to a specified area. The home's pain assessment for an identified date also indicated the resident had pain in another specified, area less than daily but more than weekly. The resident was ordered a PRN pain medication, for pain or fever. This was documented as administered in the eMar on an identified date and not again for three months. The eMar and progress notes only indicated the medication was given and had not indicated if the medication was given for fever or pain. Interview with the RPN on the floor indicated that the resident was sometimes observed to experience discomfort but often refused pain medication when offered; however, this was not documented. Interview with the MDS RAI Coordinator indicated they did not know why the identified medication had been given, based on review of the documentation, and confirmed the home's policy was to monitor the resident's pain through detailed documentation indicating the reason for the administration of the PRN drug along with the effectiveness/outcome of the resident in response to the PRN administration. [s. 134. (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was: (b) reported to the resident, the resident's SDM.

On an identified date, at an identified time, an identified resident was involved in a medication incident when they received a medication which they should not have received. The RPN was immediately aware of the medication incident and monitored the resident. The resident was overheard asking why they had to be monitored so frequently. A review of the clinical record and Medication Incident Report on an identified date did not indicate the resident or the SDM was notified of the incident. Interview with the A/DOC confirmed the licensee had failed to ensure that the resident and the resident's SDM were notified of the medication incident on a specified date. [s. 135. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 146. When licensee shall discharge

Specifically failed to comply with the following:

s. 146. (4) A licensee shall discharge a long-stay resident if,
(a) the resident is on a medical absence that exceeds 30 days; O. Reg. 79/10, s. 146 (4).
(b) the resident is on a psychiatric absence that exceeds 60 days; O. Reg. 79/10, s. 146 (4).
(c) the total length of the resident's vacation absences during the calendar year exceeds 21 days; or O. Reg. 79/10, s. 146 (4).
(d) the long-term care home is being closed. O. Reg. 79/10, s. 146 (4).

Findings/Faits saillants :

1. The licensee has failed to discharge a long-stay resident if, (c) the total length of the resident's vacation absences during the calendar year exceeds 21 days.

Census records for an identified resident revealed the resident was absent from the home on vacation leave for 29 days in an identified year. The Business Office Manager confirmed this absence and that the bed was held. The total length of the resident's vacation absence during the calendar year exceeded 21 days as provided in the legislation. [s. 146. (4) (c)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A review of the clinical records for three identified residents did not show that these residents were offered immunization against tetanus and diphtheria. The RAI Coordinator who is also in charge of Infection Prevention and Control confirmed on an identified date that these immunizations were not offered to these residents. [s. 229. (10) 3.]

Issued on this 22nd day of May, 2015

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

Original report signed by the inspector.