Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2019	2018_569508_0024 (A2)	029149-17, 030098-18	Resident Quality Inspection

Licensee/Titulaire de permis

859530 Ontario Inc. (operating as Jarlette Health Services)
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Royal Rose Place
635 Prince Charles Drive North WELLAND ON L3C 0C7

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

Amended by ROSEANNE WESTERN (508) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

N/A

Issued on this 27th day of March, 2019 (A3)

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

Original report signed by the inspector.

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

Amended by ROSEANNE WESTERN (508) - (A3)

Amended 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 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, December 3, 5, 6, 7, 10, 2018.

During the course of the inspection, the inspector(s) toured the home, observed

meal services, observed the provision of care, reviewed resident's clinical records, the home's complaint log, internal investigative notes, staffing schedules, documentation related to education provided to staff, relevant policies and procedures, Resident Council minutes and Family Council minutes.

PLEASE NOTE: The following compliant inspections were conducted concurrently during this RQI;

-Log #010457-17 related to skin and wound;

-Log #027666-17 related to menu planning, laundry services and nursing and personal care;

-Log #007817-18 and Log #009597-18 related to insufficient staffing;

-Log #017747-18 related to skin and wound, continence care, falls prevention and management;

-Log #022259-18 related to nursing and personal care, falls prevention and management;

-Log #029901-18 related to plan of care, nutrition, resident Bill of Rights and improper transfers.

The following Critical Incident (CI) inspections were conducted concurrently during this RQI;

-Log #006713-17 related to a fall resulting in injury;

-Log #023995-17 related to an incident resulting in injury;

-Log #001200-18 related to a fall resulting in injury;

-Log #009027-18, related to responsive behaviours;

-Log #009214-18 related to responsive behaviours;

-Log #011345-18 related to responsive behaviours;

-Log #011688-18 related to responsive behaviours;

-Log #017667-18 related to responsive behaviours;

-Log #022672-18 related to a fall resulting in injury;

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nurse Managers, Staff Educators, Resident Assessment Instrument (RAI) Coordinator, Environmental Manager, Registered Dietitian, Nutrition Manager,

Dietary Aides, Physiotherapist (PT), Resident and Family Services Coordinator, Life Enrichment Coordinator, registered staff, Personal Support Workers (PSWs), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

10 WN(s)
7 VPC(s)
1 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_575214_0015	508

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. 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 failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff that used a clinically appropriate assessment instrument that was specifically designed for skin and wound.

During review of the resident's clinical records it was identified that resident #013 had multiple areas of altered skin integrity. The resident was admitted to the home on an identified date in 2016. The resident started developing wounds in 2017, and over a period of time continued to develop altered areas of skin integrity and required wound care.

Wound care records were reviewed for a specific period of time. During review of the resident's clinical records it was identified that on an identified date in 2017, skin assessments using a clinically appropriate assessment instrument had been conducted on two specific areas.

Another assessment using a clinically appropriate assessment instrument was not completed for one specific area until eight days later, and no further assessments had been conducted using a clinically appropriate assessment instrument for the other area until 17 days later.

On an identified date in 2017, a Physician's note in the resident's clinical record indicated that the resident had a specific diagnosis related to altered skin integrity. On an identified date in 2017, a weekly skin assessment was conducted of a specific area of the body. Another assessment had not been completed until two weeks later and then not again until two weeks after that. Although a review of the electronic Treatment Administration Records (e-TARs) for two identified months in 2017 indicated that treatments were being provided, weekly skin assessments were not consistently being conducted.

On an identified date in 2018, a new area of altered skin integrity was identified and a treatment had been ordered. No further skin assessments using a clinically appropriate assessment instrument were conducted for several weeks.

For an identified period of time in 2018, the resident developed new areas of altered skin integrity. The resident's other wounds were still present as well. A review of the clinical records indicated that for four months in 2018, weekly skin assessments using a clinically appropriate instrument had not been conducted consistently on all areas of altered skin integrity.

It was confirmed through review of the clinical records and during interviews with the RAI Coordinator that the licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident who exhibited 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, when clinically indicated.

During review of the resident's clinical records it was identified that resident #013 had multiple areas of altered skin integrity. The resident was admitted to the home on an identified date in 2016. The resident started developing wounds in 2017, and over a period of time continued to develop altered areas of skin integrity and required wound care.

Wound care records were reviewed for a specific period of time. During review of

the resident's clinical records it was identified that on an identified date in 2017, skin assessments using a clinically appropriate assessment instrument had been conducted on two specific areas.

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It was confirmed through review of the clinical records and during interviews with the RAI Coordinator that the licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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. [s. 50. (2) (b) (iv)]

3. The licensee failed to ensure that the resident who exhibited 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, when clinically indicated.

A review of the clinical records for resident #011 indicated that on an identified date in 2018, resident #011 had alteration in their skin integrity related to a specific diagnosis.

During a review of the resident's clinical records, including the wound notes, e-TARs and wound assessments, it was identified that wound assessments were not being conducted at least weekly by a member of the registered nursing staff.

A record review identified that for an identified time period in 2018, the assessments were not consistently being conducted weekly.

It was confirmed during records reviews and during interview with Nurse Manager #204, that resident #011 had altered skin integrity and had not been reassessed at least weekly by a member of the registered nursing staff, when clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

(A3)(Appeal/Dir# DR# 111)
The following order(s) have been rescinded: CO# 001

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 resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds 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, to be implemented voluntarily.

WN #2: 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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Resident #013 was identified as a risk for falls and falls interventions had been implemented in the resident's plan.

A review of the resident's clinical record indicated that on an identified date in 2018, during a check on the resident, the resident was observed laying on the floor. It was determined during a post fall assessment of the resident's fall, that one of the resident's fall intervention was not in place.

The RAI-Coordinator attended the post fall discussion after this fall and during an interview, it was confirmed that staff had initially applied this intervention; however, after providing care to the resident did not re-apply this intervention.

It was confirmed during review of the resident's clinical records and during an

interview with the RAI Coordinator that the care set out in the resident's plan of care related to falls prevention had not been provided as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

During review of the clinical records, it was identified that resident #013 was admitted to the home on a specific date in 2016 and was identified as a risk for falls.

The resident resided in the home for an identified number of years and sustained multiple falls during this time. During review of the resident's clinical record it was identified that these falls were un-witnessed.

Review of the resident's falls plan of care, the post fall assessments and progress notes indicated that interventions had been implemented; however, had not always been effective. It was also identified that interventions were not always implemented after the resident had fallen or before the resident sustained another fall.

It was confirmed through review of the resident's clinical record and during interview with the RAI Coordinator, that the licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective as the resident continued to fall or roll out of their bed. [s. 6. (10) (c)]

3. The licensee failed to ensure that when the resident was reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

During a review of the clinical record it was identified that resident #013 had a history of a specific diagnosis. A review of the resident's plan of care indicated that interventions had been implemented to minimize the resident's risk in developing complications related to this diagnosis.

On an identified date in 2017, an order was received from the Registered Dietitian (RD) to provide additional fluids at specific times of the day in addition to fluids offered at meal and snack times.

On a specific date in 2018, resident #013 was admitted to hospital for interventions related to their diagnosis. While in hospital a referral form had been sent to the RD for fluid requirements not being met.

A review of the Medication Administration Records (MAR) for a specific time period in 2018, indicated that the resident was regularly taking these additional fluids.

A review of the MAR for an identified month in 2018, indicated that the resident regularly refused their fluids; specifically at an identified time. A dietary referral was submitted by RN #103 due to the resident's fluid requirement not being met for an identified period. The RD received this referral the same day and further indicated that the resident did not meet their fluid requirements for an identified period of time.

Further review of the resident's MARS over a three month period, indicated that the resident regularly refused their fluids or were sleeping at the time of administration.

It was confirmed during review of the resident's clinical record and during interview with the RAI Coordinator that when the plan of care was being revised because care set out in the plan had not been effective, different approaches had not been considered in the revision of the plan of care. [s. 6. (11) (b)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with Ontario Regulation 79/10, r. 49(1) which requires every licensee of a long-term care home to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of a Critical Incident Submission (CIS) #3049-000001-18, log #001200-18, indicated that on an identified date in 2018 resident #005 was found on the floor. The resident was assessed and noted to be guarding a specific area on their body and demonstrating that they were in pain. The resident was transferred to hospital and diagnosed with an injury. The resident returned back to the Long Term Care home with a specific device in place.

A review of the home's fall policy titled, "Falls Prevention and Management-Program" with a revised date of 2017-12-29, indicated on page two of six that Registered Staff:

A) Will ensure that all residents;
-Are asked on admission about falls history and same is documented.

-Are indicated to be high falls risk on admission until further risk assessment is completed and appropriate interventions initiated to address admission risk.
-Are orientated to their surroundings on admission, and assisted to set up room so that they may exit bed on their stronger side as applicable.

B) Will ensure that, in addition, a resident with risk for falls;
-Has falls risk identified and care plan developed immediately related to this risk if resident is new admission and/or resident/substitute identify falls as problem/potential problem.
-Is referred to physiotherapy using the Resident Rights, Care and Services-Required Programs-Falls Prevention and Management-Physiotherapy Falls Referral Guide.
-Is referred to the pharmacist and/or physician for a review of medications that may put resident at risk for falls, as applicable.
-Is referred to physician/Nurse Practitioner (NP) for screening for osteoporosis and for assessment of need for Vitamin D and/or Calcium supplementation.
-Is screened for vision/hearing assistance needs and the resident/substitute is supported in accessing assessment of these needs and in addressing these needs.
-Is screened for need for appropriate and safe foot wear and resident/substitute are supported in obtaining same. The use of slippers for mobile residents is discouraged.
-Is assessed for nutritional contributors (poor food and fluid intake, or low body weight) to dizziness/confusion, and referred as appropriate to dietary.
-Has communication logo indicating high risk for falls, posted at bed side and on assistive device (if applicable) if has had fall in past 30 days coded on most recent quarterly assessments.

During an interview with the RAI Coordinator, it was determined that the resident was not a risk for falls on their admission and became a risk for falls on an identified date, when they sustained a fall with injury that resulted in a significant change to their health status. The RAI Coordinator confirmed that upon becoming a risk for falls, a referral to the pharmacist and/or physician for a review of medications that may put the resident at risk for falls, as applicable, was unable to be located; a referral to the physician/NP for screening for osteoporosis was unable to be located; screening for the need for appropriate safe foot wear, was unable to be located. Review of the resident's clinical record and interview with the RAI Coordinator confirmed that upon the resident being identified as a fall risk, a care plan was developed immediately related to this risk and other interventions

had been completed.

An interview with the Administrator and RAI Coordinator confirmed that the home's policy in relation to falls prevention and management, had not been complied with for resident #005.

B) Resident #013 was admitted to the home on an identified date in 2016, and was identified as a risk for falls. The resident sustained multiple falls over an identified period of time.

During interview with the RAI Coordinator, it was confirmed that the home did not comply with their Falls Prevention policy.

During this inspection the RAI Coordinator reviewed the resident's records and could not locate the following:
- a referral to the pharmacist and/or physician for a review of medications that may put the resident at risk for falls, as applicable;
- a referral to the physician/NP for screening for osteoporosis;
- a screening for the need for appropriate safe foot wear.

It was confirmed during interview with the RAI Coordinator and record reviews that the home did not comply with the Falls Prevention and Management policy for resident #013. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with section 11 (1) (b) which requires every licensee of a long-term care home to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents.

During a review of the clinical record it was indicated that resident #001 had not been receiving the quantity of fluids that had been documented on a previous report.

Observation of a meal was conducted during this inspection. Resident #001 was observed to have beverages provided.

A review of the resident's current electronic care plan indicated under interventions for eating, that the resident was to be provided their fluids in a specific device and were to receive a specific amount of fluids daily and a specific intervention with meals. A document titled, Fluid Documentation", that was provided by the Registered Dietitian, and identified the sizes of cups, mugs and glasses, measured in millilitres as well as an interview with PSW staff #165 confirmed that the cup the resident received, contained a specific amount of fluid.

During the meal, the resident was observed to have had approximately 50 ml of juice and approximately 220 ml of the other fluid. A review of the Point of Care (POC) task, titled, "Nutrition: Meals (1000 ml goal)", contained a follow up question that asked the amount of fluid consumed in mls. A review of documentation in this task indicated that the first documentation for this date was entered at a specific time and recorded a specific amount of fluid consumed. A review of the Task Details document indicated that this entry had been recorded as a late entry by PSW staff #149. An interview with PSW staff #149 was conducted. The staff member indicated that they had not documented the fluid entry for the resident. The Long Term Care Homes (LTC homes) Inspector indicated that their name was listed on the task details form as being the staff that completed the documentation for fluids consumed at this meal. The staff member confirmed that they had not been the staff that provided fluids to the resident and were unsure which staff they spoke to regarding the quantity of fluids consumed, when they documented the amounts. The staff member indicated that the quantity of fluids documented may be a mistake and were unable to confirm if the breakfast fluid amount documented, had been an accurate quantity.

A review of the homes policy, titled, "Nutrition Care and Hydration Programs- Hydration Assessment and Monitoring", with an effective date of 2018-03-01, indicated that it was the responsibility of the PSW and Life Enrichment staff to enter all fluid consumed into the POC program.

A review of the homes policy, titled, "Nursing Routines- Personal Support Worker Routine-0600-1400" with a date of May 15, 2016, and provided by the DOC, indicated that between 0830-0915 hours, staff were to serve beverages by choice and appropriate assigned diet and to document intake on POC.

An interview with the Administrator indicated that documentation of fluids consumed was to be accurate and to occur as soon as the action was provided. The Administrator confirmed that the homes policy and procedure in relation to

the documentation of fluids, had not been complied with for resident #001. [s. 8. (1) (a),s. 8. (1) (b)]

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 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 is in compliance with and is implemented in accordance with applicable requirements under the Act and O. Reg. 70/10, in accordance with r. 49(1) and s.11(1)(b), to be implemented voluntarily.

WN #4: 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 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 resident #007's electronic Treatment Administration Record (e-TAR), for a specific time period in 2018, indicated that the resident was to have a specific treatment completed on a specific date on an identified shift.

A review of the e-TAR for the identified periods indicated that no documentation had been entered for the resident's monthly treatments.

No documentation was able to be located that the treatment had been done one specific date as ordered.

An interview with Staff Educator #196, confirmed that no documentation had been in place on the e-TAR or in the resident's progress notes that indicated that the resident's treatment had been completed.

A telephone interview was conducted with registered staff #125, who had been scheduled as working on that identified date and time. The staff member indicated that they did not have time to complete all of the treatments on their shift and had verbally informed incoming registered staff #123, that they were unable to complete resident #007's treatment as scheduled. Registered staff #125 confirmed that they had not documented on the residents e-TAR or in their progress notes that the treatment was unable to be completed or that they informed registered staff #123. A telephone interview with registered staff #123 indicated that the staff member could not recall if registered staff #125 had verbally informed them that the resident's treatment had not been completed, as scheduled. Registered staff #123 indicate that if any treatments had not been completed, they would complete these and document in the resident's progress records. Registered staff #123, indicated that they were unable to recall if they completed the resident's treatment or not and confirmed that they had not documented any actions in regards to the treatment.

An interview with the DOC confirmed that actions taken with respect to the completion of resident #007's treatment had not been documented. [s. 30. (2)]

2. B) During a complaint inspection, log #017747-18, it was identified that resident #013 had a specific treatment which was to be completed on an identified shift, on a specific date.

A review of the e-TARs for an identified period of time in 2018, indicated that on one date in 2018, the resident refused their treatment. The resident's clinical records indicated that there was no further documentation in the resident's clinical record to indicate if the treatment was completed.

The resident also had another treatment ordered. On the same date, there was no documentation to indicate if this was completed as there was an omission on the resident's e-TAR.

During interview with the RAI Coordinator they indicated that it would be the expectation that staff should have documented the actions taken when the resident refused and if the treatment was done on another date and there should not have been an omission on the e-TAR related to their treatments.

The LTCH Inspector attempted to contact registered staff #124 who had documented the refusal and left an omission on the e-TAR; however, the staff was unavailable.

It was confirmed during a review of the resident's clinical record and during interview with the Nurse Educator, that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were to be documented. [s. 30. (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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. PLEASE NOTE: This area of non compliance was identified during a CIS inspection, Log #011345-18, conducted concurrently during the RQI.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

A) A review of Critical Incident (CI) log #011345-18 identified an incident of responsive behaviour that occurred on an identified date in 2018, between resident #017, and #002. It was identified that resident #017 was physically responsive to resident #003, resulting in resident #002 falling.

A review of the written plan of care for resident #017 identified that this resident exhibited responsive behaviours, in the form of verbal and physical aggression due to cognitive impairment. The written plan of care further identified that resident #017 had an intervention in place for their responisve behaviours. A review of progress notes at the time of the incident indicated that the home did not have this intervention in place when this incident occurred.

In an interview with registered staff #118 and the DOC, it was confirmed that this intervention was not implemented to minimize the risk of altercations between and amongst residents. [s. 54. (b)]

2. PLEASE NOTE: This area of non compliance was identified during a CIS

inspection, Log #009214-18, conducted concurrently during the RQI.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

B) A review of Critical Incident (CI) log #009214-18 identified an incident of responsive behaviour that occurred on an identified date in 2018, between resident #018, and #017. It was identified that resident #018 was physically responsive to resident #017.

A review of the written plan of care for resident #018 identified that this resident exhibited responsive behaviours. They were identified to be unpredictable, and without provocation.

A review of the written plan of care for resident #017 identified that this resident exhibited responsive behaviours due to cognitive impairment. The written plan of care further identified that resident #017 had an intervention in place. A review of CIS report indicated that the home did not have this intervention in place due to staffing challenges at the time of this incident.

In an interview with the DOC it was confirmed that resident #017 did not have their intervention in place on this identified date in 2018. It was further confirmed that this intervention was not implemented to minimize the risk of altercations between and amongst residents. [s. 54. (b)]

3. PLEASE NOTE: This area of non compliance was identified during a CIS inspection, Log #09027-18, conducted concurrently during the RQI.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

C) A review of Critical Incident (CI) log #009027-18, identified an incident of responsive behaviour that occurred on an identified date in 2018, between resident #018, and #017. It was identified that resident #018 was physically responsive to resident #017.

A review of the written plan of care for resident #018 identified that this resident

exhibited responsive behaviours. The responsive behaviours were identified to be unpredictable, and without provocation.

A review of the written plan of care for resident #017 identified that this resident exhibited responsive behaviours due to cognitive impairment. The written plan of care further identified that resident #017 had an intervention in place. A review of CIS report indicated that the home did not have this intervention in place at the time of the incident.

In an interview with registered staff #113 they confirmed that this intervention was not in place at the time of this incident. In a subsequent interview with the DOC it was confirmed that resident #017 did not have the intervention in place at the time of this incident. It was further confirmed that this intervention was not implemented to minimize the risk of altercations between and amongst residents. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

A review of a Critical Incident Submission (CIS) #3049-000001-18- log #001200-18, indicated that on an identified date, resident #005 had retired to bed when staff heard the resident calling out. The resident was found on the floor. The resident was assessed and noted to be guarding a specific area on their body and demonstrating signs of pain. The resident was transferred to hospital and diagnosed with an injury. The resident returned back to the Long Term Care home with a specific device in place. The CIS indicated that at the time of the fall their falls intervention was not functioning.

A review of a Post Fall Assessment progress note indicated that the resident's falls intervention was not functioning and that staff responded when they heard the resident calling out.

During an interview with the Administrator and the RAI Coordinator, it was indicated that they were unsure why the falls intervention was not working at the time of the resident's fall. The Administrator indicated that in the past, the home had on occasion, some issues with call bells and bed alarms being connected at the same time in one room and not functioning properly; however, would function properly in another resident room.

An interview with the Administrator confirmed that the home did not have a policy in place to ensure that all equipment, devices and assistive aids, specifically clip bed alarms, were kept in good repair. The Administrator confirmed that the procedure in place was to document every shift in POC and that at the time of the

resident's fall, their falls intervention was not working. [s. 90. (2) (b)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

A review of a Complaint Submission, Log #022259-18 took place during this inspection. One portion of this complaint included a concern that resident #014's falls intervention had not been functioning properly, causing this resident to sustain a fall.

A review of a Post Fall Assessment progress note indicated that resident #014's falls intervention did not work properly at the time of the fall.

In an interview conducted with registered staff #102 it was confirmed that the fall intervention for resident #014 did not function properly at the time of this residents fall. It was further confirmed that this fall intervention was displaced and not functioning properly.

During an interview with the DOC it was confirmed that the fall intervention did not function properly at the time of resident #014's fall. In an interview conducted by Inspector #214 with the administrator it was confirmed that the home did not have a policy in place to ensure that all equipment, devices and assistive aids, including bed alarms, were kept in good repair. [s. 90. (2) (b)]

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 are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the resident's personal aids or equipment, 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).

Findings/Faits saillants :

1. The licensee 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.

A review of a Complaint Submission log #023883-18 indicated that a medication error occurred with resident #001.

A review of the homes medication incident on an identified date in 2018, identified that resident #001 was administered a specific medication during the morning medication pass. The medication incident was not detected until the Controlled Substance Shift Count took place, and identified that the count for this medication, and resident #001's other medication count was not accurate.

A review of the e-MAR (electronic medication administration record) for an identified month in 2018 was reviewed, and revealed that resident #001 should have been administered the other medication during the morning medication pass.

The progress notes for this identified date indicated that resident #001 was drowsy, and slept through the morning, and was not awake for lunch. Resident #001 was placed in bed for comfort.

During an interview with registered staff #121, it was confirmed that resident #001 was administered a medication that had not been prescribed for this resident.

During this inspection an interview took place with the DRC, and it was confirmed that medication incident occurred, and resident #001 was administered a medication that had not been prescribed for this resident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug was prescribed for the resident, to be implemented voluntarily.

WN #8: 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 failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Royal Rose Place is a 96 bed Long Term Care Home which required a Registered Nurse (RN) to be in the building twenty-four hours/seven days a week (24/7). The RNs employed at the home work eight hour shifts consisting of days, evenings and night shifts.

During complaint inspections, log #007817-18 and #009597-18, conducted concurrently during this Resident Quality Inspection (RQI), staffing schedules were reviewed for April and May, 2018. It was identified that over the course of the two months that there were four shifts where the home had no staff RN in the building. The following dates and shifts are as follows:

- April 16, 2018 from 1400 - 2200 hours;
- April 17, 2018 from 0600 - 1400 hours;
- April 28, 2018 from 1400 - 2200 hours;
- May 2, 2018 from 1400 - 2200 hours;

The home had an additional Registered Practical Nurse (RPN) on duty on these dates and at times the Director of Care was on-call if not in the building; however, it was confirmed during interview with the Administrator on December 5, 2018, that this did not meet the requirement of having at least one RN who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

A review of complaint log #023883-18, and confirmed with the complainant, indicated that the menu, specifically, the starched item, had not always been provided.

During a dining observation, it was observed that the posted daily and weekly menu for this lunch hour meal identified that the starched item of buttered noodles was to be served.

During this dining observation, resident #002 was observed to have an identified textured meal. The textured starch item that this resident received, appeared to be mashed potatoes. An interview with dietary aide staff #219, confirmed that the resident had received mashed potatoes. The staff member indicated that the buttered noodles had been prepared in certain textures only.

During an interview with the Nutrition Manager and staff #217, staff #217 confirmed that the buttered noodles had not been prepared in the a certain texture as the previous Nutrition Manager had crossed off the pureed buttered noodles on the production sheet and listed mashed potatoes in place.

The current Nutrition Manager indicated that pureed buttered noodles should have been provided or if mashed potatoes were being substituted, this should have been communicated on the posted menus. The Nutrition Manager confirmed that not all of the planned menu items, specifically, pureed buttered noodles had been offered and available at the lunch hour meal on November 15, 2018. [s. 71. (4)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that they sought the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

During this inspection, an interview with resident #019, president of the Residents' Council and an interview with the president of the Family Council, on the same date, indicated that both councils were not sought out for their advice in developing and carrying out the Satisfaction Survey for 2018. An interview with the Administrator, indicated that they had provided the survey to the manager(s) to be taken to both councils; however, confirmed that they were unsure which manager(s) were to complete the survey and no documentation was in place to identify that this had been completed for the Residents' and Family Council. [s. 85. (3)]

Issued on this 27th day of March, 2019 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by ROSEANNE WESTERN (508) - (A3)
Inspection No. / No de l'inspection :	2018_569508_0024 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	029149-17, 030098-18 (A3)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 27, 2019(A3)
Licensee / Titulaire de permis :	859530 Ontario Inc. (operating as Jarlette Health Services) c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Royal Rose Place 635 Prince Charles Drive North, WELLAND, ON, L3C-0C7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Helen Jovicich

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 859530 Ontario Inc. (operating as Jarlette Health Services), you are hereby required to comply with the following order(s) by the date(s) set out below:

(A3)(Appeal/Dir# DR# 111)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of March, 2019 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by ROSEANNE WESTERN (508) - (A3)

Service Area Office / Bureau régional de services : Hamilton Service Area Office