Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Original Public Report

Report Issue Date: May 2, 2023

Inspection Number: 2023-1477-0004

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: 859530 Ontario Inc. (operating as Jarlette Health Services)

Long Term Care Home and City: Royal Rose Place, Welland

Lead Inspector	**Inspector Digital Signature**
Carla Meyer (740860)	Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.05.09 14:34:22 -04'00'

Additional Inspector(s)
Stephanie Smith (740738)
Brittany Wood (000763) was present and shadowed the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 29th-31st, 2023 and April 3rd-6th, 11th, and 12th, 2023

The following intake(s) were inspected:

- Intake: #00018873 - [Follow-up] related to Skin and wound care.
- Intake: #00001092 - Complaint related to nutrition, palliation, and falls.
- Intake: #00019018 - Complaint related to Infection Prevention and Control and dining and snack service.
- Intake: #00004822 - [CI: 3049-000055-22] related to injury of unknown cause
- Intake: #00012440 - [CI: 3049-000079-22] related to improper / incompetent care of a resident.
- Intake: #00014593 - [CI: 3049-000086-22] related to neglect of a resident.

The following intake(s) were completed:

- Intake: #00012138 - [CI: 3049-000078-22]; Intake #00002206-[CI: 3049-000032-22]; Intake #00007079-[AH: IL-01903-AH/CI: 3049-000035-22] were all related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 246/22	s. 55 (2) (b) (ii)	2022-1477-0003	001	740860

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Pain Management
Palliative Care
Prevention of Abuse and Neglect
Resident Care and Support Services
Skin and Wound Prevention and Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary

A resident room was observed to have no call bell present. There was a bed pressure alarm connected to the communication response system and a one-to-one staff member present. A Registered Practical Nurse (RPN) acknowledged that the resident did not have a call bell present as their care needs had changed, indicating that the call bell posed a safety risk. RPN acknowledged that the care plan was not updated to reflect this change and that it should have been.

There was minimal risk to the resident when their care plan was not revised when their care needs changed.

Sources: Observations; interview with a RPN and others; resident clinical record.

[740738]

WRITTEN NOTIFICATION: Conditions of Licence
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (3)

The licensee has failed to ensure that they complied with the agreement made under the Connecting Care Act, 2019.

Specifically, the licensee did not complete three Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments including: discharge with return anticipated, re-entry, and discharge with return not-anticipated for a resident within the required timeframes.

Rationale and Summary
As per the home's Long-Term Care Home Service Accountability Agreement (LSAA) under the Connecting Care Act, 2019, the licensee was required to meet the practice requirements of the RAI-MDS system which included conduction of quarterly assessments of residents, and all the other assessments of residents required by the RAI-MDS Tools, using the RAI-MDS Tools.

According to the RAI-MDS 2.0 manual, a resident can be readmitted following a previous discharge by completing the re-entry items in the Admission/Re-Entry record at the time of re-entry to the facility. Additionally, the Discharge record is required whenever a resident dies or is discharged from the facility and must be completed at the time when the resident is discharged from the facility.

A resident had a fall on an identified date and was subsequently sent to hospital. The resident died shortly after their return to the home. The Staff Educator/RAI-MDS acknowledged that the resident did not have three RAI-MDS assessments completed including: discharge with return anticipated, re-entry, and discharge with return not-anticipated and did not complete the assessments until April 2023.

Sources: Interview with Staff Educator/RAI-MDS; resident clinical record; Long-Term Care Home Service Accountability Agreement (LSAA) April 2023-March 2024; Resident Assessment Instrument (RAI) MDS 2.0 User's Manual, Canadian Version, February 2012.

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WRITTEN NOTIFICATION: Required programs
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

A) The licensee has failed to ensure that the Falls Prevention and Management program provided for assessment and re-assessment instruments.

In accordance with O. Reg 246/22, s. 11(1) (b), the licensee is required to ensure that the Falls Prevention and Management program provided for assessment and re-assessment instruments.

Specifically, staff did not comply with the policy titled LTC Emergency Care - Head Injury Routine, revised February 15, 2022, which indicated that for any unwitnessed fall, head injury routine (HIR) must be completed. This policy was included in the licensee's Falls Prevention and Management program.

Rationale and Summary
A resident had a fall on a day in November 2022 and sustained a head injury. Staff did not comply with the home's HIR policy and procedure for the resident during this time. Specifically: hold medications until the resident has been assessed for head injury and the physician has provided orders; and, notify the physician of the assessment completed and seek orders for treatment. The Director of Care (DOC) acknowledged that staff did not follow the home's HIR policy.

Failure to ensure the home's HIR policy was complied with, led to increased risk of negative impact to the resident.

Sources: Interview with DOC and other staff, resident clinical record, the home's investigation notes, CI: 3049-000086-22, the home's policies titled LTC Emergency Care - Head Injury Routine and LTC Falls Prevention and Management - Program

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B) The licensee failed to ensure that the Pain Management program provided for assessment and reassessment instruments.

In accordance with O.Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that there is a Pain Management program that provides for assessment and reassessment instruments and is complied with.

Specifically, the home did not complete the required quarterly pain assessments for a resident as per the home's policy.

Rationale and Summary
The home's policy titled "Pain Management – Program," stated that every resident is to be assessed for pain, regardless of level of cognition, on admission, quarterly and routinely as required.

A resident's assessment records showed that pain assessments were being completed since their admission, until an identified date. There were no other pain assessment records for this resident until a day in December 2020, where they were assessed to have exhibited pain based on a Pain Assessment in Advance Dementia (PAINAD) scale. For the year of 2021, there were only two pain assessments completed for the resident. On a day in July 2022, the resident had a change in status and exhibited pain, and a PAINAD scale was completed. Quarterly pain assessments were initiated in Point Click Care (PCC) on a day in October 2022.

The Administrator confirmed that pain assessments were to be completed quarterly in PCC, and acknowledged that there were missing quarterly pain assessments for the resident as per the home's policy for the time period stated above.

By not completing routine pain assessments for the resident, they were placed at risk for improper pain management.

Sources: Interview with the Administrator; resident assessment records, and the home's policy titled "Pain Management – Program," last revised March 6, 2022, page 2.

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WRITTEN NOTIFICATION: Pain Management
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that a pain assessment for a resident was completed, when a new onset of pain was observed.

Rationale and Summary
A resident who was previously ambulatory and exhibited wandering behaviors was assessed to have had a change in status and pain to their leg based on a PAINAD scale. An as needed "pro re nata" (PRN) pain

medication was administered by a Registered Nurse at this time which indicated little effectiveness based on a follow up pain assessment using the PAINAD scale on the same day.

The resident's medication administration records indicated that this was the first time this PRN medication was being administered since May 2022, and the resident was not on regular pain medication. The resident's last recorded PAINAD assessment was on a day in December 2021.

Several days later, the resident was again assessed by a Registered Practical Nurse (RPN) to have exhibited pain and was subsequently sent to the hospital where they were diagnosed with an injury. The RPN confirmed that if a resident experienced new onset of pain, a pain assessment would be completed. A RN also stated that if a PRN pain medication was administered, a pain assessment in PCC under the assessment tab would have been opened.

The home's policy titled, Pain Management – Program, also stated that the registered staff will ensure that every resident regardless of level of cognition will have a comprehensive pain assessment under assessments in PCC completed with any new pain, and with pain related to change in medical condition.

By not completing the appropriate pain assessment tool for the resident with new onset of pain, the resident was placed a risk for ineffective pain management.

Sources: Interview with a RPN and RN; review of resident clinical records, and the home's policy titled, "Pain Management – Program," last revised March 6, 2022.

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WRITTEN NOTIFICATION: Nutritional care and hydration program
NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee failed to comply with the system to measure and record a resident's weight.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a weight monitoring system to measure and record each residents' weight on admission and monthly thereafter and must be complied with.

Specifically, the home did not comply with the policy "LTC Monthly Weights and Weight Variance Report", last revised on March 24, 2021, as part of the licensee's Nutrition and Hydration Program, where they were required to measure and record a resident's weight on admission and monthly and if

there is a change of 7.5% of body weight, or more, over three months, and actions were to be taken to address the concern.

Rationale and Summary
In December 2021, a resident's weight was not measured and documented. Their progress note did not indicate that they had refused, and no record of re-approach was documented. Their clinical records indicated that they were at a moderate nutritional risk.

The resident was assessed by a Registered Dietician (RD) #125 on a day in December 2021 and acknowledged through documentation that the resident did not have their December weight measured and recorded. The RD did not order a reweigh, nor make any changes to the resident's plan of care. The Nutritional Manager (NM) acknowledged that because the resident was missing a monthly weight, they should have been weighed at that time. In January 2022, another RD #126 assessed the resident for a referral due to an unrelated concern and noticed a decline in the resident's weight taken earlier that month. RD #126 ordered a reweigh of the resident and confirmed that the resident had a significant weight loss over a two-month period and was not meeting their nutritional needs and ordered to start the resident on dietary supplements.

The Director of Care (DOC), a Registered Practical Nurse (RPN), and a Personal Support Worker (PSW) confirmed that a resident's weight was to be measured monthly between the first and tenth of the month and stated that resident refusal would be documented in the progress note, and the resident would be re-approached to ensure that their weight was taken.

By failing to monitor and record the resident's weight, their weight loss was missed which impacted the ability to ensure appropriate actions were taken to address the concern and placed the resident's health and well-being at risk.

Sources: Interview with the DOC, an RPN, a PSW, and the Nutritional Manager; review of resident clinical records, and the home's policy titled, LTC Monthly Weights and Weight Variance Report, last revised on March 24, 2021.

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WRITTEN NOTIFICATION: Dining and snack service
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee failed to comply with their dining and snack service process of measuring and recording

food temperatures prior to meal service.

In accordance with O. Reg 246/22 s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have a policy or program in place, the policy or program is complied with.

Specifically, staff on the second-floor servery did not record food temperatures prior to serving lunch on a day in March 2023 as per the home's policy where it states that Point of Service (POS) temperatures for all menu items are to be recorded approximately five minutes prior to the commencement of the meal on the Food Temperature & Waste Tracking Tool.

Rationale and Summary
Food temperature logs were reviewed on the second-floor servery due to a concern regarding food being served too hot. Upon review, it showed that there were no temperatures recorded on the Food Temperature & Waste Tracking Tool form on a day in March 2023, and this was acknowledged by a Dietary Aid. This form was reviewed on two separate days, and temperatures remained undocumented.

The Nutritional Manager (NM) and Dietary Aid stated that food temperatures were to be checked before serving and recorded.

By not measuring and recording the food temperature prior to serving the meals, there was a risk of serving food outside of acceptable range and the ability to take corrective action as needed was impacted.

Sources: Interview with NM and Dietary Aid; and review of the home’s Food Temperature & Waste Tracking tool, and policy titled, “LTC Point of Service Food Temperatures & Waste Tracking,” last revised on February 14, 2023.

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