Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2018	2018_668543_0004	000661-18	Resident Quality Inspection

Licensee/Titulaire de permis

Autumnwood Mature Lifestyle Communities Inc.
130 Elm Street SUDBURY ON P3C 1T6

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

Cedarwood Lodge
860 Great Northern Road SAULT STE. MARIE ON P6B 0B5

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

TIFFANY BOUCHER (543), JENNIFER LAURICELLA (542), LISA MOORE (613)

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): January 29-31, 2018 and February 1, 2, 5-8 and 12-16, 2018

Additional intakes inspected during this Resident Quality Inspection (RQI) included:

Five follow-ups, one related to Plan of Care, two related to Abuse, one related to Falls and one related to Restraints.

Seven complaints, four related to care concerns, one related to Family Council concerns, one related to Abuse and one related to Maintenance concerns.

Three critical incident reports, two related to Abuse and one related to continence care.

Throughout the inspection, the Inspectors observed the delivery of care and services to residents in all home areas, reviewed resident health care records, internal investigation documents, resident and family council meeting minutes and various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Physician Assistant (PA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Assessment Instrument Coordinator (RAI), Life Enrichment Manager and Scheduling Manager, 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
Minimizing of Restraining
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 this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **3 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. 110. (1)	CO #005	2017_655679_0010	542
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2017_655679_0010	542
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2017_655679_0010	542
O.Reg 79/10 s. 49. (2)	CO #004	2017_655679_0010	542
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_655679_0010	542

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. 6. Plan of care

Specifically failed to comply with the following:

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 resident #010's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During a staff interview, resident #010 was identified as having a fall in the last 30 days.

Inspector #543 reviewed the resident's progress notes that indicated that the resident had fallen on three separate occasions in 2018.

The Inspector reviewed resident #010's most recent care plan which identified that the resident had a risk for falls characterized by a history of falls. The care plan did not identify a specific intervention related to falls.

Inspector #543 interviewed PSW #111 and #112 who indicated that the resident required a specific intervention related to falls.

The Inspector interviewed RN #107 who identified that the resident required a specific intervention and verified that resident #010's care plan was not revised to identify such an intervention. [s. 6. (10) (b)]

2. 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 care set out in the plan had not been effective.

Inspector #613 reviewed a critical incident (CI) report that was submitted to the Director on a day in 2018, identifying witnessed abuse between residents #016 and #002.

A review of resident #016 and #002's progress notes revealed that both residents had been involved in two previous altercations that had occurred on two separate occasions, as a result of the two residents being in close proximity to one another.

Inspector #613 reviewed resident #016 and #002's care plans. There was no other documentation to identify that preventative interventions had been added to either residents' care plans after the altercations. New intervention to monitor and keep residents separated were only initiated after a third altercation incident.

During an interview with RN #101, they reported they were aware of the previous alterations and verified that the care plan had not been updated with preventative measures until after the third altercation between the two residents had occurred.

During an interview with the Administrator, they confirmed that resident #016's and #002's care plan should have been updated after each incident had occurred to prevent recurrence. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #010 is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the care set out int he plan has not been effective, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a document record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A review of the home's policy titled, "Complaints Procedure – Communications #02-03-02" last revised March 2011, identified that the home shall ensure that a documented record was kept in the home. The record shall include:

-the nature of the written/verbal complaint
-date complaint had been received
-type of action taken to resolve the complaint (include date of action, time frames for actions to be taken and any follow up action)
-final resolution
-every date on which any response had been provided to the complainant
-every date on which a response was made by the complainant

During an interview with the Administrator, Inspector #613 requested the documented records of all verbal and written complaints. The Administrator verified that they were unable to locate records, after the former Administrator left in December 2017, and that they did not have a record of verbal or written complaints. [s. 101. (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 a documented record is kept and that the documented record is reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a physician or a registered nurse in the extended class (RNEC) attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Inspector #542 observed resident #008 on February 7, 8 and 13, 2018, with a restraint.

A health care record review was completed for resident #008. The resident's most recent care plan indicated that they required a restraint.

Inspector #543 reviewed the home's Restraints-Physical policy (#05-03-02) with a review date of September 13, 2017. The policy identified that a resident's condition would be reassessed and the effectiveness of the restraining device evaluated only by a physician, a RNEC attending the resident or a member of the registered nursing staff at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Inspector #542 was unable to locate any documentation that indicated that registered staff were reassessing the resident's condition and the effectiveness of the restraint being used at least every eight hours and at any other time when necessary based on the resident's condition or circumstances.

Inspector #542 interviewed PSW #102 and #110 who verified that resident #008 required the restraint. [s. 110. (2) 6.]

2. Resident #010 was observed with a restraint.

Inspector #543 reviewed resident #010's most recent care plan which identified that the resident required a restraint. The interventions included, but were not limited to reassessing the resident's condition and the effectiveness of the restraining device evaluated by the RN/RPN every eight hours; a signature on the electronic medication administration record (e-Mar) was also required.

Inspector #543 was unable to locate any documentation that indicated that registered staff were reassessing the resident's condition and the effectiveness of the restraint being used at least every eight hours and at any other time when necessary based on the resident's condition or circumstances.

The Inspector interviewed RPN #108 who verified that the registered staff did not reassess the condition or the effectiveness of the restraint every eight hours for residents who required a restraint.

The Inspector interviewed the Administrator who verified that registered staff had not documented or reassessed the residents' restraints every eight hours. [s. 110. (2) 6.]

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 resident #008 and #010's condition is reassessed and the effectiveness of the restraining is evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances., 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,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

During a staff interview and a census record review, resident #006 was identified as having impaired skin integrity.

A review of the home's policy titled, "Skin Care Program/Wound Management #02-05-01" last revised February 2011, identified that the policy provided guidelines to all members of the health care team in the prevention and treatment of skin breakdown. The focus of the program would be on prevention. A Risk Assessment would be completed within 24 hours of resident's admission, upon any return of the resident from hospital and upon any return of the resident from an absence of greater than 24 hours".

A review of resident #006's progress notes revealed that the resident had been transferred to the hospital on a specific day in 2018, and returned to the home 13 days later. Resident #006's progress notes did not identify a skin assessment upon their return to the home from the hospital.

During an interview with RN #101, they verified that registered staff were expected to complete a head to toe skin assessment when a resident returned from hospital and verified that there was no documentation to support that a head to toe skin assessment had been completed upon resident #006's return from hospital.

During an interview with the Administrator, they verified that registered staff were expected to complete a skin assessment when a resident was returned from hospital; as it was clearly stated in the home's policy, and resident #006 had been at risk of skin breakdown after being hospitalized. [s. 50. (2) (a) (ii)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM), if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Inspector #613 reviewed a critical incident (CI) report that was submitted to the Director on a date in 2018, identifying witnessed abuse between residents #016 and #002.

A review of the home's policy titled "Zero Tolerance To Resident Abuse and Neglect - Resident Safeguards" last revised July 2017, revealed that the Administrator would arrange for a follow-up care conference with the resident/family/SDM, of both victim and abuser, to discuss the outcome of the investigation.

During an interview with the Administrator, they verified that they had not notified resident #016 and #002's SDM's of the result of the investigation, immediately upon the completion of the investigation. [s. 97. (2)]

Issued on this 21st day of February, 2018

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

Original report signed by the inspector.