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

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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
Nov 30, 2017	2017_546585_0022	025184-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

PEEL MANOR
525 MAIN STREET NORTH BRAMPTON ON L6X 1N9

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

LEAH CURLE (585), HEATHER PRESTON (640), KATHLEEN MILLAR (527)

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 6, 7, 8, 9, 10, 14 and 15, 2017

Concurrent to this Resident Quality Inspection (RQI), five additional inspections were conducted:

Three Critical Incident System (CIS) inspections:
CIS log #022354-17 related to staff to resident abuse
CIS log #023642-17 related to falls prevention and management
CIS log #002865-17 related to staff to resident abuse

Two Complaint inspections:
Complaint log #020761-17 related to reporting and complaints, skin and wound care and personal support services
Complaint log #021990-17 related to prevention of abuse and neglect, personal support services, continence, dining and snack service and hospitalization and change

During the course of the inspection, the inspector(s) spoke with Residents, families, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), dietary staff, housekeeping staff, Supervisors of Care (SOC), the nursing clerk, Physiotherapist (PT), Supervisor of Facility Service, Supervisor of Activation and Volunteers, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed resident care and services, staff to resident interactions, reviewed documents which included but were not limited to: resident clinical health records, policies and procedures, assessment tools, logs, training records and program evaluations.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #001 had an alteration in skin integrity, which was identified on a specified date in 2017. The clinical record was reviewed and the physician ordered treatment for the alteration. The physician's order was transcribed onto the electronic treatment administration record (eTAR) and on to the written plan of care.

Registered Practical Nurse (RPN) #124 and Supervisor of Care (SOC) #106 were interviewed and indicated that according to the clinical record, the resident had an alteration in skin integrity on a specified area; however, confirmed the alteration was located on a different area. Although the written plan of care included direction to staff to treat alteration in skin integrity; RPN #124 and SOC #106 confirmed the written plan of care did not provide clear direction as the physician's order and transcription throughout the clinical record inaccurately identified the location of the area of altered skin. The

home failed to ensure that resident #001's plan of care provided clear direction to the staff who provided direct care. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) Resident #003 had a physician's order for a specified device. On an identified date in August 2017, staff made a referral to physiotherapy to conduct an assessment of the resident and device. The Physiotherapist (PT) conducted an assessment and recommended a referral to the Occupational Therapist (OT) to assess the resident.

The clinical record was reviewed, which identified the recommendations by the PT; however there was no referral to the OT to assess the resident.

RPN #124 was interviewed and was not aware of the referral to OT and was not aware of any recommendations by the PT. RPN #124 was not aware of any strategies or interventions that were implemented as a result of the PT and/or OT assessments. SOC #106 was interviewed and after reviewing the clinical record they identified the PT referral made in August 2017, and the subsequent recommendations for OT to conduct an assessment; however was unable to locate any assessment by OT and/or recommendations to address the concerns.

The PT was interviewed and confirmed their recommendation for OT to assess the resident. They indicated that when they needed a referral for OT, the process was to email the SOC, they in turn would email their contracted service representative, and subsequently they contact the OT related to the referral of the resident. Interview with SOC #126 confirmed that the PT had emailed the SOC requesting an OT referral, but was unable to locate any information that the assessment was completed for resident #003.

The home failed to ensure that the staff and others involved in the different aspects of care and assessments of resident #003 were integrated, consistent and complemented each other.

B) Resident #004's admission and quarterly Resident Assessment Instrument - Minimum Data Set (RAI-MDS) revealed they were assessed as needing a specified device. Their

clinical record also revealed their continence had deteriorated since admission and the Registered Dietitian assessed them as at risk nutritionally on both the admission and quarterly RAI-MDS assessments.

During the inspection, the device specified as an intervention in the RAI-MDS assessments was not observed as being in place. RN #135 was interviewed and confirmed that the resident had altered skin integrity. RN #135 confirmed that the nurse who assessed the resident on admission and quarterly identified the resident as needing the device.

The home failed to collaborate with each other in the skin assessments of the resident #004 so that their assessments were integrated and were consistent with and complemented each other.

C) On a specified date in 2017, resident #001 was assessed as having altered skin integrity and had a history of altered skin integrity. The quarterly RAI-MDS completed in September 2017, identified that they required a device(s). The clinical record was reviewed and their weekly skin assessments were completed; however no preventative skin and wound care interventions were identified. The resident was assessed by the Registered Dietitian as moderate risk nutritionally on the quarterly RAI-MDS assessment.

The home's policy, "Skin and Wound Care Program" last revised June 27, 2016, directed staff to implement preventative measures according to the residents' preferences, wishes and needs, including turning and repositioning and pressure relieving devices.

Multiple observations of the resident and their environment were made during the inspection, and no devices or interventions were in place. RPN #124 was interviewed and confirmed the resident had altered skin integrity and there were interventions were implemented to address the alteration, including a physician's order and weekly skin assessments; however, confirmed they was not aware that the quarterly RAI-MDS assessment had identified the resident needed preventative skin care measures implemented and what those interventions were.

The home failed to collaborate with each other in the skin assessments of resident #001 so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

On a specified date in 2017, resident #014 experienced a fall. The post-fall assessment directed staff to complete a continence assessment and review of the toileting schedule and readjust to meet the resident's needs.

The Long-Term Care (LTC) Homes Inspector reviewed the resident's clinical record and was unable to identify a toileting schedule for resident #014. During an in-depth review of the written plan of care, there was a noted toileting schedule under the Skin focus, directing staff to toilet the resident at multiple scheduled times in a 24 hour period. A toileting schedule was also observed in the resident's room.

The resident's continence care look-back report for a two week period in 2017 was reviewed. All entries made did not reflect the identified toileting times and on 12 of the 14 days. Interview with PSW #115 and PSW #107 confirmed there were no specific times to toilet the resident. PSW #115 demonstrated where they would look on Point of Care (POC) to review the toileting care needs and showed on POC the toileting task which identified every shift (Q shift). PSW #115 also demonstrated on the kardex available to the staff, the toileting focus, which did not include any specified times to toilet, just how to toilet the resident.

PSW #115 directed the LTC Homes Inspector to the posting in the resident's room, but was not aware of the specific times. PSW #107 and PSW #115 were not aware of the scheduled toileting times set out for the resident in the written plan of care.

The above noted non-compliance was identified during the inspection of Critical Incident System (CIS) log #023642-17. [s. 6. (8)]

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 and ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 Regulation required the home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system; the plan, policy, protocol, procedure, strategy or system was complied with.

A) In accordance with Ontario Regulation (O. Reg.) 79/10, s.48 requires the licensee to ensure that the interdisciplinary programs, including a falls prevention program, are developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

On a specified date in 2017, resident #014 experienced a fall that resulted in an injury. The resident was assessed and interventions were put in place to prevent further falls. One intervention noted was to assess continence and toileting schedule, readjust

schedule according to the resident need.

The home's policy, "Falls Prevention and Management Program", revised October 24, 2016, directed staff to manage continence – assess bowel and bladder needs and develop an individualized program.

The resident's clinical record was reviewed and the LTC Homes Inspector was unable to locate a continence assessment related to the identified intervention in post fall assessment. Interview with RPN #109 and the DOC were unable to identify the continence assessment as identified in the post fall assessment. RPN #109 and the DOC confirmed the home did not complete the continence assessment as referred to in the post fall assessment and as per the home's policy.

The above noted non-compliance was identified during the inspection of CIS log #023642-17.

B) In accordance with O. Reg. 79/10, s. 114 (2) requires the licensee is to have written policies and protocols for the medication management system.

The home's pharmacy policy, "Drug Inventory Control", last reviewed January 16, 2017, directed staff to identify, destroy and dispose of expired medications.

i) On November 10, 2017, the LTC Homes Inspector observed expired government stock on the Blue Jay Way unit, which included:

- Three (3) 500 millilitre (mL) bottles of Potassium Chloride Oral Solution 20 milliequivalents (mEq) per 15mL, which expired September 2017; and
- A container of 100 tablets of Multivitamins without Minerals, which expired September 2017.

Interview with RPN #124 confirmed that when they checked the government stock that they were expected to remove any expired medications for destruction and re-order another supply of those medications, if needed.

ii) On November 14, 2017, the LTC Homes Inspector observed expired government stock on the Broddy Way unit, which included:

- Three (3) 500 mL bottles of Potassium Chloride Oral Solution 20 mEq per 15mL, which

expired December 2016;
- A container of 100 tablets of Multivitamins without Minerals, which expired September 2017; and
- Senekot 1000 tablets, which expired October 2017.

Interview with RN #135 confirmed that if they identified any medications from the government stock that was expired, they were expected to remove them for destruction and re-order new medication, if needed.

The home failed to comply with their Drug Inventory policy and procedures for expired medications. [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 and 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, the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The home failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences; and a record was kept of the date, the participants and the results of the conferences.

The home's policy, "Documentation - Care Conferences, Policy Number LTC1-5.30", revised November 4, 2010, directed staff to hold a multi-disciplinary care conference within six weeks of admission or sooner if needed, annually after the initial admission conference and encourage the resident/Substitute Decision Maker (SDM) to participate. The policy also directed the Registered Nurse take minutes of the meeting and document into the progress notes under "Care Conference Note" in Point Click Care after the meeting.

A) Resident #003 had no annual care conference since 2015. The clinical record was reviewed and the LTC Homes Inspector was unable to locate the documentation related to the annual care conference for 2016 or 2017. RPN #109 was interviewed and indicated that they conduct annual care conferences with the resident and/or SDM to discuss the resident's care with the multidisciplinary team and any concerns can be addressed at this time, as well as if any consents needed, they can be obtained. SOC #106 was interviewed and confirmed that there was an annual care conference

scheduled for 2017, but was unsure as to why it did not take place.

The home failed to ensure that at least annually there was a care conference for resident #003, to discuss the plan of care and any other matters of importance to the resident/SDM; the resident's SDM was not given an opportunity to participate fully in the conferences; and there was no record kept of the date, the participants and the results of the conference.

B) Resident #012's clinical record was reviewed and the LTC Homes Inspector was unable to locate notes from the six week post admission care conference and an annual care conference. The resident's electronic clinical record was reviewed with the Resident Assessment Instrument (RAI) Coordinator who confirmed there was no documentation to confirm a six week post admission care conference was conducted. The hard copy of the clinical record was reviewed with SOC #106 who located a record of the admission care conference dated for a specified month in 2017. The document was blank with a reference to see Point Click Care (PCC) for progress notes. The LTC Homes Inspector and the RAI Coordinator reviewed PCC and were unable to locate any progress notes related to an admission and annual care conference. SOC #106 confirmed there was no evidence to support that a six week post admission care conference was held.

During an interview with staff member #131 who was responsible to schedule all care conferences, they reported the six week post admission care conference was scheduled for a specified date in 2017. They confirmed there was no documentation to confirm the conference occurred. During review of the clinical records with staff member #131 and their office records, staff member #131 confirmed there was no documentation that an annual care conference, required to be scheduled in 2016, occurred and also confirmed the annual care conference had not been scheduled. The licensee failed to ensure a care conference was held within six weeks of admission and annually after that.

The above noted non-compliance was identified during the inspection of complaint log #020761-17. [s. 27. (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 and ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and a record is kept of the date, the participants and the results of the conferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas of any other areas provided for in the regulations, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

Subsection 221. (2) 1. of O. Reg. 79/10 defined intervals for the purpose of subsection 76 (7) of the Act to be completed at annual intervals.

The licensee failed to ensure that all direct care staff were provided training annually, as required under O. Reg 79/10 s. 221. (1), in the area(s) of: 5. All staff who apply physical devices or who monitor residents restrained by physical devices, receive training in the application use and potential dangers of these physical devices.

Review of the home's 2016 staff education content for restraints revealed that the education did not include information regarding the application and use of physical devices, which was confirmed in an interview with SOC #130. [s. 76. (7) 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 and ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping, procedures were developed and implemented for cleaning and disinfection resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs in the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's cleaning and disinfection instructions for the System 2000 bath tub included direction as follows: scrub the surfaces of the bathtub, loose parts and accessories with a soft bristle brush or cloth to remove any deposits such as skin flakes. Scrub thoroughly. Rinse all parts clean with plenty of water. Wet a new cloth with water and remove all traces of disinfectant on contact areas.

On November 6, 2017, during an initial tour of the home, the bath tub in the Goreway home area spa room was observed. Dry brown debris was present in the bottom of the tub and around the drain. RN #141 confirmed the tub was unclean. A second observation was made of the tub on November 10, 2017, at which time light brown dried residue was present on the side of the tub and around the drain. PSW #122 confirmed the debris could be removed and tub was not cleaned as in accordance with the manufacturer's specifications for cleaning and disinfecting of tubs. [s. 87. (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 and ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more resident,

the investigation should be commenced immediately.

The home received a written complaint from resident #012's family on a specified date in 2017, which outlined multiple concerns regarding care and services.

The home’s policy, "Reporting and Managing Complaints and Recommendations - Policy Number: LTC1-05.05" (no revision date noted), directed staff to respond in writing to the complainant regarding the resolution within 10 days of receipt of the written complaint.

The home's written response to the complainant was reviewed. The home's response was dated over two months after the date the complainant submitted the letter, and did not address all of the components outlined in the written complaint.

The DOC was interviewed and confirmed the letter was not sent within the required 10 days and the written response did not include the resolution to all of the complainant's concerns.

The above noted non-compliance was identified during the inspection of complaint log #020761-17. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented 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.

The home’s 2017 complaint logs was reviewed and did not include the written complaint received by the home on a specified date in February 2017 regarding resident #012.

The home’s policy, "Reporting and Managing Complaints and Recommendations - Policy Number: LTC1-05.05" (no revision date noted), directed staff to keep a written record of the following for all complaints not resolved within 24 hours: (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.

The DOC was interviewed and confirmed there was no record kept in the home for the written complaint received in February 2017, regarding resident #012.

The above noted non-compliance was identified during the inspection of complaint log #020761-17. [s. 101. (2)]

3. The licensee failed to ensure that, (a) the documented record of complaints received was reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis were taken into account in determining what improvements were required in the home; and (c) a written record was kept of each review and of the improvements made in response.

During a review of the home's complaints program, the LTC Homes Inspector requested the quarterly analysis of the complaints received by the home for the 2016 calendar year.

The home's policy, "Reporting and Managing Complaints and Recommendations - Policy Number: LTC1-05.05" (no revision date noted), directed staff to review and analyze all documented complaints for trends at least quarterly, results of the analysis to be considered to determine improvements to make in the home and a written record to be kept of each review and of the improvements made in response.

The DOC and SOC #126 were interviewed and confirmed the home did not review or analyze complaints received quarterly for the calendar year 2016 and therefore there were no improvements determined as a result and no written record was kept.

The above noted non-compliance was identified during the inspection of complaint log #020761-17. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately; that a documented record is kept in the home that includes, (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, and; (a) the documented record is reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and (c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

i) On a specified date in November 2017, resident #016 was observed with a physical device applied. A space of several inches was found between the resident and the device. Interview with PSW #140 revealed they did not know how to apply the device. RPN #136 reported the device was used as a restraint and confirmed it was not applied appropriately.

ii) On a specified date in November 2017, resident #017 was observed with a physical device applied. A space of several inches was found between the resident and the device. Interview with PSW #139 reported the device was applied appropriately. Interview with RPN #124 reported the device was a restraint and confirmed it was not applied appropriately. PSW #139 adjusted the device and left the resident. RPN #139 re-assessed PSW #139's adjustment and confirmed the device was still not applied appropriately.

Interview with SOC #126 was unable to locate the specific manufacturer's instructions for the devices; however, provided manufacturer's instructions of a similar device which stated when applied, the device should be tight without causing discomfort or undue

pressure.

The licensee failed to ensure that resident #016 and resident #017's physical devices were applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 4. Consent.

On multiple dates in November 2017, resident #003 was observed with a physical device applied.

Review of the clinical record revealed the resident had a physician's order for a restraint. The order indicated that the resident was to be reassessed, verify for effectiveness and ongoing need.

The clinical record was reviewed and the last consent form on the hard copy chart was from 2015 and there was no further documentation that a consent was obtained for the restraint in 2016 or 2017.

The home's policy, "Minimizing Restraint use and the use of Personal Assistance Services Devices (PASD) Program", revised March 27, 2017, directed registered staff to obtain consent for application of the ordered restraint from the resident and/or substitute decision maker (SDM), documenting the discussion on the "Restraint Assessment and Consent Form", number IDF-038.

The home's policy, "Resident Consent - Consent to Medical Care and Treatment - number LTC9-05.01.1", last revised February 18, 2011, directed staff that the consent form must be renewed annually.

RPN #124 was interviewed and indicated that when a resident was restrained, they were expected to obtain a consent and they were to ensure there was a physician's order for the restraint. SOC #106 was interviewed and they indicated that at the time of the resident's annual care conference, they will validate consent for restraints with the resident and/or SDM and it would be documented in the Care Conference Summary in Point Click Care (PCC). There was no documentation of an annual care conference since 2015 and no documentation related to validation of consent with the SDM for the restraint.

The home failed to ensure that there was a consent from the SDM for resident #003's physical device to restrain. [s. 110. (7) 4.]

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 and ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

The home's policy, "Medication Storage - Medication Cart" last reviewed January 16, 2017, directed the RNs and RPNs to keep medication carts locked at all times when not in use.

On November 7, 2017, the LTC Homes Inspector observed the medication cart on the Fountainview unit in the hallway and unlocked. There was no RN or RPN visible in the hallway. All five drawers of the medication cart were accessible to residents that were wandering the hallway. The medication cart drawers contained medications and medication related supplies for all residents.

On November 8, 2017, the LTC Homes Inspector observed the medication cart from Blue Jay Way hallway unlocked and there was no RN or RPN visible in the hallway. The inspector was able to open all of the medication drawers, which contained medications and medication related supplies for all residents.

RPN #101 was interviewed on November 7, 2017, and indicated that they were expected to lock the medication carts when the cart was not visible to them and/or when not in use. RPN #113 was interviewed on November 8, 2017, and confirmed that they were expected to keep the medication carts locked when not in use and had forgotten to lock the medication cart.

Interview with SOC #106 confirmed that the registered staff were expected to keep their medication carts locked at all times when they were not being used, or when the cart was not visible to them. The home failed to ensure that the medication carts were secured and locked. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect or residents, and shall ensure that the policy was complied with.

The home's policy, "Prevention, Reporting and Elimination of Abuse/Neglect, Policy Number LTC1-05.01" (no revision date noted), directed staff that when an allegation of verbal abuse occurred, the person must immediately make a report to the Director of the MOHLTC.

On a specified date in 2017, the home submitted a Critical Incident Report/CIS log # 022354-17 regarding an allegation of staff to resident abuse. According to the Critical Incident Report, RPN #114 received information regarding an allegation of staff to resident abuse on a specified date in 2017.

The DOC was interviewed and confirmed the home was aware of the allegation on a specified date in 2017; however, the allegation of abuse was not reported to the Director until over 10 days after RPN #113 was first made aware of the allegation. The DOC confirmed RPN #114 did not comply with the home's policy to immediately report the allegation of abuse to both the Administration of the home and the Director.

The above noted non-compliance was identified during the inspection of CIS log #022354-17. [s. 20. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) The home's annual Skin and Wound Care Program evaluation for 2016 was reviewed and based on the results of the program evaluation, there were changes implemented in order to improve resident outcomes; however there was no date as to when those changes were implemented. The target date for each change was identified as ongoing on the written record and the date implemented each change was blank. The DOC was interviewed and confirmed that there was no specific date identified on the written annual program evaluation related to when the changes were implemented based on the results of the program evaluation.

The home failed to ensure that there was dates documented on the written annual program evaluation for Skin and Wound care related to when the changes were implemented.

B) The home's annual Fall Prevention program annual evaluation for 2016 was reviewed and based on the results of the program evaluation, the home did not include, on the written record, the date changes were implemented to the program. Interview with Supervisor of Care #106 confirmed the dates of implementation of the changes was not included in the written record.

The above noted non-compliance was identified during the inspection of Critical Incident System (CIS) log #023642-17.

C) The home's annual Continence Care and Bowel Management Program evaluation for 2016 was reviewed and based on the results of the program evaluation, there were changes implemented in order to improve resident outcomes; however there was no date as to when those changes were implemented. The target date for each change was identified as ongoing on the written record and the date implemented each change was blank. The DOC was interviewed and confirmed that there was no specific date identified on the written annual program evaluation related to when the changes were implemented based on the results of the program evaluation. [s. 30. (1) 4.]

WN #11: 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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Resident #001 had area of altered skin integrity, which was identified on a specified date in October 2017. The clinical record was reviewed and there was no referral to the Registered Dietitian (RD) when the alteration was identified.

The home's policy, "Skin and Wound Care Program" last revised June 27, 2016, directed registered staff to make a referral to the RD for assessment of residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

RPN #124 was interviewed and confirmed that the resident had an area of altered skin integrity and that as part of their policies, were expected to make a referral to the RD for assessment. RPN #124 was unable to locate any referral to the RD on the clinical record. SOC #130, who was also the skin and wound care lead for the home, was interviewed and confirmed that resident #001 should have had a referral to the RD when area of altered skin integrity was identified.

The home failed to ensure that resident #001 was assessed by a RD when the resident exhibited an alteration in skin integrity. [s. 50. (2) (b) (iii)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #010's clinical record revealed that on admission, a Bladder and Bowel Continence Assessment was completed, as well as a MDS Admission assessment, and identified the resident as continent of bladder.

On a specified date in August 2017, progress notes and Point of Care (POC) documentation indicated the resident experienced bladder incontinence. The quarterly MDS assessment completed in September 2017, also identified the resident experienced bladder incontinence.

Interview with PSW #119 and RPN #112 confirmed the resident was initially continent of bladder; however, became incontinent of bladder. RPN #112 reported that when the resident was identified as incontinent, a Bladder and Bowel Continence Assessment should have been completed; however, was unable to locate an assessment. Interview with the DOC confirmed the expectation was for staff to complete a Bowel and Bladder Continence Assessment when a resident is found to be incontinent and confirmed no assessment was completed when resident #010 was identified as incontinent of bladder. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to eat safety and drink as comfortably and independently as possible.

Resident #009's plan of care stated they required assistance from staff with eating. On a specified date in November 2017, the resident was observed attempting to eat independently but was not successful. The resident did not receive assistance from staff and consumed less than 25 per cent of their meal. Interview with RPN #112 reported the resident required assistance from staff to eat and that staff were expected to assist the resident when they did not appear to be eating. The home failed to sure that resident #009 received the personal assistance and encouragement they required for eating. [s. 73. (1) 9.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when a written complaint with respect to a matter that the licensee was to report under section 24 of the Act, was received, the licensee submitted a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101(1).

On an identified date in 2017, the home was given a written complaint that included multiple concerns regarding the care of the resident #012.

The home’s policy, "Reporting and Managing Complaints and Recommendations, Policy Number LTC1-05.05" (no revision date noted), directed staff that when a written complaint was received by the home about the care of the resident or the operation of the home and its services, a copy along with the response must be submitted to the Ministry of Health and Long-Term Care (MOHLTC).

The DOC confirmed in an interview that the home did not submit the copy of the written complaint and the response to the complainant to the Director.

The above noted non-compliance was identified during the inspection of complaint log #020761-17. [s. 103. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that the written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.

The home's annual Restraints program evaluation for 2016 was reviewed and no dates were identified of when the changes and improvements were implemented. Interview with the SOC #106 confirmed that there were no specific dates of the changes; however, the changes were ongoing. Interview with the DOC confirmed that there were some with dates and some identified as ongoing on the annual program evaluation related to the changes and improvements. The home failed to identify the date that the changes and improvements were implemented. [s. 113. (e)]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.