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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2017	2017_324535_0004	029519-16, 031307-16, 031436-16, 032048-16, 032961-16, 034445-16	Complaint

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET TORONTO ON M6G 3C3

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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 8, 9, 10, 13, 14, 15, 16, 17, 20,21,22, 23, 24, 27, April 3, 4, 20, 21, 24, 25, 26, 27, and 28, 2017.

During the complaint inspection the following intakes were inspected: #034445-16 related to skin and wound; 032961-16 related to pest control; and 031436-16 & 031307-16 both related to responsive behavior and falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Administrator, Director of Nursing (DON), Nurse Managers (NMs), Acting NM, Physician, Food and Nutrition Duty Manager, Geriatric Mental Health Outreach Team member (GMHOT), Behavior Support Clinic Lead, Physiotherapist(PT), Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Associate (PCA), dietary aide, housekeeping staff, and substitute decision makers.

During the course of the inspection, the inspectors observed the provision of care, reviewed clinical records, staff education records, Critical Incident System record, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

10 WN(s)
5 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

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

Findings/Faits saillants :

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

The MOH received an identified complaint on an identified date related to resident #023 regarding plan of care.

Record review revealed that on an identified date a practitioner was consulted regarding a condition related to the resident. On an identified date, the practitioner assessed the resident and responded on the consult form a suggested strategy in future to prevent the recurring condition. The progress notes also revealed that this preventative strategy was not updated to the resident's written care plan as to prevent the recurrent condition; six week later, the resident was assessed with the condition again.

During an interview, registered staff RPN #185 acknowledged that the information was not included in the resident's written care plan to support the prevention of recurrence. During an interview, the Nurse Manager stated that the expectation was for registered staff to update resident's written care plan to ensure the plan was based on an interdisciplinary assessment. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The MOH received an identified complaint on an identified date, related to resident #002 and regarding the plan of care.

Record review revealed that resident #002 was admitted to the home on an identified date. The progress notes revealed that the resident had an identified behavior. The RAI assessment and therapists assessments all indicated that the resident was at high risk for falls. The plan of care revealed that on an identified date, the resident was assessed

as having a fall; however the resident's condition was not managed with interventions. Record review also revealed that on an identified date after assessment of the resident, the therapist documented two recommendations.

Record review revealed that the resident experienced an identified number of falls over a period of of three months and that most of the falls occurred at a particular time period. During an interview, PCA # 175 and RPN # 207 stated that previously during an identified month and during the particular time periods, interventions were put in place to manage the resident's behavior. On an identified date, the resident experienced a fall and another again a couple of weeks later which led to the resident being transferred to hospital. Therefore, on an identified date the resident's substitute decision-maker informed the home to stop the intervention.

During an interview, the Nurse Manager stated that the expectation was for registered staff to assess each resident individual needs and preferences and implement interventions to ensure safety for the resident. [s. 6. (2)]

3. The licensee has failed to ensure that 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 complement each other.

The MOH received an identified complaint on an identified date related to resident #002 and regarding immediate assessment and treatment of results.

Record review revealed that resident #002 was admitted to the home on an identified date with a diagnosis. Record review also revealed that on an identified date, resident #002 had an incident and was transferred to an acute care facility for assessment; however the resident was returned to the home shortly afterwards, and had no ill effects. The progress notes indicated that as a result of the incident, the physician ordered a test to be completed. Further review revealed that on an identified date, the physician wrote an order to please get test result. A review of the test results showed that the result was received on that same date by the registered staff; however, the progress notes revealed that the test result was filed in the physician's book for review and not called immediately to the physician for discussion and an order for treatment. The progress notes also revealed that one week later, the physician wrote an order for medication.

During an interview, registered staff # 174 and #176 both confirmed that the test result

should have been called immediately to the physician for treatment and not placed in the physician book. During an interview, the Nurse Manager confirmed the same information; and also stated that the expectation was that registered staff review test results contact the physician immediately for discussion and appropriate treatment. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The MOH received an identified complaint on an identified date, related to resident #022 regarding the substitute decision maker (SDM) participation in the development in the plan of care.

Record review revealed that on an identified date, the registered staff documented that the resident had a condition; and on another identified date, the registered staff documented that the resident had a second condition. The progress notes also revealed that the staff documented referrals made to the registered dietitian, occupational therapist and physiotherapist; however, there was no documentation related to notifying the resident's SDM of these conditions. During an interview, the SDM stated that he/she was not informed of the resident's conditions by the home. During interviews, registered staff RN #182 stated that he/she could not recall if the family was informed of the resident's conditions at the time of discovery; but acknowledged that the notifications were not documented in the resident's chart. [s. 6. (5)]

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

The MOH received an identified complaint on an identified date, related to resident #002 and regarding the plan of care.

Record review revealed that resident #002 was admitted to the home on an identified date with a diagnosis; and was assessed using the Resident Assessment Instrument (RAI) as having a behavior.

Record review revealed that on an identified date, the resident had a fall which resulted in injury and required transfer and admission to the acute care hospital. The progress notes also revealed that upon readmission to the home, the residents written care plan

was updated to include an intervention; close monitoring; and with the initiation of a device.

During an observation on an identified date, the inspector observed that the device monitoring form was fully completed and signed for the day shift up to and including the end of the shift, and it was approximately lunch time. During an interview, registered staff RPN #174 confirmed that the form was completed for the shift by the other staff who was off the unit at the time. During an interview, the Nurse Manager stated that the expectation was that registered staff documented on the monitoring form only after the direct observation and assessment was completed with the resident, then the actions would be documented. [s. 6. (7)]

6. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

The MOH received an identified complaint on an identified date, related to resident #002 and monitoring and documentation in the plan of care.

Record review revealed that resident #002 was admitted to the home on an identified date with a diagnosis. The progress notes revealed that the resident had an identified behavior. The RAI assessment and therapists assessments all indicated that the resident was a high risk for falls. Record review revealed that on an identified date, the resident experienced a fall and was admitted to the acute care hospital. The resident's written care plan was updated to include an identified intervention; and with the initiation of a device and a form to be used.

During interviews, personal care associate #115 and registered staff RPN #174 and RPN #176 stated that did not have the form indicated in the written plan of care but used another identifed form. A review of the other forms used by the staff on an identified date, confirmed that the forms were being used as per the written plan of care sometimes, and also to capture other information related to the use of the device and the resident's related actions.

During an interview, the Nurse Manager confirmed that the staff did not have a separate form for documenting the resident's hourly monitoring; and that staff also used another monitoring form when the resident required monitoring. The Nurse Manager stated that the expectation was for staff to use the special device monitoring form to capture specific information related to the device used for the resident. [s. 6. (9) 1.]

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

The MOH received an identified complaint on an identified date, related to resident #002 regarding the plan of care.

Record review revealed that resident #002 was admitted to the home on an identified date with a diagnosis. The progress notes revealed that the resident had a behavior. The RAI assessment and therapists assessments all indicated that the resident was a high risk for for falls. Record review also revealed that on an identified date after assessment of the resident, the therapist documented two recommendations. The progress notes revealed that on an identified date the resident experienced a fall; however, the home did not implement additional intervention until after the resident experienced another fall on an identified date, which resulted in injury. During an interview, PCA # 115 stated that he/she does not recall a particular prevention strategy in place prior to the incident. A review of the post incident documentation completed by the registered staff who worked that shift revealed that the registered staff documented in the new strategies for that prevention strategy to be place. Record review revealed that on an identified date, after the resident returned from hospital following the incident, an identified therapist also recommended the prevention strategy be set in place. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care for the resident;
-to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences;
-to ensure that 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 are integrated and are consistent with and complement each other;
-to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other;
-to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care;
-to ensure that the care set out in the plan of care is provided to the resident as specified in the plan;
-to ensure that the provision of care set out in the plan of care is documented; and
-to ensure that if a resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee has failed to ensure that care provided was included in the resident's plan of care.

The MOH received an identified complaint on an identified date, related to resident #002.

On an identified date, the inspector observed resident #002 sitting with a device applied in a common area. The inspector confirmed the same observation with registered staff RPN #174 and RPN #175; and both staff confirmed that the resident was in fact seated with a device applied as an identified intervention. During an interview, PCA # 175 stated that after morning care, the device the device was usually applied. The inspector also observed that the resident did not have that identified device included in the plan of care. During an interview, the Nurse Manager stated that the expectation was that the resident's plan of care should reflect the position with interventions and strategies in place to ensure safety. [s. 31. (1)]

2. The MOH received an identified complaint on an identified date, related to resident #022.

During an interview, the primary personal care associate (PCA) #206 stated that after providing care, the resident is seated with a device applied. During an interview, registered staff RPN #182, stated that the PCAs would automatically apply the device to the resident. The RPN further stated that the resident did not have that information included in the resident's plan of care.

A review of the written care plan did not include the identified positioning for the resident. During an interview, the Nurse Manager stated that the expectation was that the resident's plan of care should have reflected the use of the device with interventions and strategies in place to ensure safety. [s. 31. (1)]

3. The licensee has failed to ensure that an order was received from the physician or the registered nurse in the extended class for the use of a restraint.

The MOH received an identified complaint on an identified date, related to resident #002 and regarding receiving an order to apply a restraint.

On an identified date, the inspector observed resident #002 sitting with a device applied while in the common area. During interviews, registered staff RPN #174 and RPN #175 both confirmed that the device was applied as a safety intervention. Registered staff RN #175 also confirmed that there was no physician order in the resident's chart for the device. During an interview, Nurse Manager #195 stated that the expectation was for registered staff to obtain an order from the physician prior to applying the device. 31. (2) 4.]

4. The MOH received an identified complaint on an identified date, related to resident #022 regarding an order to apply a restraint.

Record review revealed that resident #022 did not have a written order by the physician or Nurse Practitioner (NP) for the use of a restraint.
During an interview, PCA #206 stated that a device was used as a safety intervention for resident #022. During an interview, registered staff RPN #182, stated that the PCAs would automatically use this device.The RPN further stated that, the resident did not have an order from the physician to use the device as a safety intervention.

During an interview, Nurse Manager #195 stated that the expectation was for registered staff to obtain an order from the physician prior to placing resident in that position. [s. 31. (2) 4.]

5. The licensee has failed to ensure that the plan of care include the consent from the resident substitute decision maker (SDM) prior to applying the device.

The MOH received an identified complaint on an identified date, related to resident #002 and regarding consent for the use of a restraint.

On an identified date, the inspector observed resident #002 sitting with a device applied while in the common area. During interviews, registered staff RPN #174 and RPN #175 both confirmed the device was applied as a safety intervention. Registered staff RN #175 also confirmed that the home did not inform the SDM and did not receive consent to apply the device. During an interview, Nurse Manager #195 stated that the expectation was for registered staff to inform the family and get consent prior to the use the device. [s. 31. (2) 5.]

6. The MOH received an identified complaint on an identified date, related to resident #022 regarding consent for the use of a restraint.

Record review revealed that there was no documentation or indication that resident #022's substitute decision maker was aware that the resident had a device applied as a safety intervention. During an interview, registered staff RPN #182, stated that the PCAs would automatically apply the device; the staff further confirmed that the family was not informed that the device was being applied. During an interview, the Nurse Manager stated that the expectation was for registered staff to inform the family of the use of any form of restraint being used for residents and receive consent prior to the use of the restraint. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that restraint by a physical device is included in the resident plan of care;
-to ensure that an order is received from the physician or the registered nurse in the extended class for the use of a restraint; and
-to ensure that the restraint plan of care include the consent from the resident substitute decision maker (SDM) prior to the use of a restraint, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The MOH received an identified complaint on an identified date, related to resident #002 and regarding staffing mix on a unit in the home.

Record review revealed that on an identified date, resident #002 sustained an injury which resulted in the resident being transferred to hospital. The progress notes and staff interviews revealed that the registered staff working the shift was on break, although remained on the unit at that time; and the personal care associate (PCA) was monitoring all residents when the incident occurred. Record review also revealed that in an identified month, the identified unit was only staffed with one PCA and one registered practical nurse (RPN) on an identified shift.

During an interview, registered staff RPN #207 and PCA #115 stated that there was limited time available to provide care and safely monitor all residents in the unit; and that it was challenging to ensure all residents were safely monitored. The registered staff also stated that with only two staff available sometimes it was very hard to complete all the care and documentation. During a request for the staffing plan and schedules for the identified unit of the home, the Administrator acknowledged that the level of staffing and the staffing mix were recently changed from the previous schedule. During an interview, the Nurse Manager confirmed that during an identified month in 2016, the identified unit was staffed with one personal care associate and one registered practical nurse during the identified; and that in a recent month in 2017, the level and mix of staffing were changed to include two registered practical nurses and one registered nurse for the same number of residents on the shift. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that the staffing plan provide for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The MOH received an identified complaint on an identified date, related to resident #023 receiving immediate care.

Record review revealed that on an identified date, the registered staff documented a new condition for the resident. The staff completed the weekly assessment record; however the progress notes and physician order indicated that the physician was not contacted for appropriate care and treatment related to the condition until a later date. In addition, an incident report was not completed and forwarded to the appropriate interdisciplinary team members as per protocol. During an interview, registered staff #170 confirmed that a physician order was not obtained on an identified date, to support the immediate treatment of the resident's condition until a later date; which therefore delayed the initiation of appropriate treatment for the condition by at least 3-4 days. During an

interview, the nurse manager stated that registered nurses were expected to contact the physician or nurse practitioner to obtain an order for all new conditions and issues to ensure immediate treatment and interventions. [s. 50. (2) (b) (ii)]

2. The MOH received an identified complaint on an identified date, related to resident #023 regarding immediate assessments and treatment of the resident's condition.

Record review revealed that on an identified date, the specialist nurse visited the home and documented a detailed assessment related to multiple conditions. The specialist nurse consultant record also stated specific information and recommendations to be communicated to the physician. The progress notes revealed that on an identified date, the physician documented reviewed and approved specialist nurse recommendations and suggestion for medication. The Medication Administration Records revealed that although the recommended medication was ordered immediately by the physician, it was noted that there was a time lag of four days after the specialist nurse assessment was completed; and that the resident was transferred to hospital shortly after with a related diagnosis.

During an interview, the Nurse Manager stated that registered staff should contacted the physician immediately to report new consult assessment and obtain the order for treatment as applicable. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The MOH received an identified complaint on an identified date related to resident #022 regarding reassessments.

Record review revealed that on an identified date, the registered staff documented that the resident had a condition and completed referrals to the registered dietitian, occupational therapist and physiotherapist; however a weekly assessment record could not be located in the resident's chart. The weekly assessment record was also missing for another identified date. The progress notes revealed that on another identified date, the registered staff documented that the resident had a condition; and again the weekly assessment record could not be located in the resident's chart.

During an interview, registered staff RN #118 confirmed that the weekly assessments

were not located in the chart and therefore concluded that the assessments were not completed on those dates. During an interview, the Nurse Manager stated that the expectation was that the registered nurse in charge of each unit completed the weekly assessment record each week for all residents with that condition. [s. 50. (2) (b) (iv)]

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 who is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required; and
-to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

The MOH received an identified complaint on an identified date, related to resident #002 and regarding minimizing altercations in the home.

Record review revealed that resident #002 was admitted to the home on an identified date with a diagnosis. The progress notes revealed that during personal care, the resident displayed a consistent behavior. The RAI assessment and therapists assessments all indicated that the resident was at high risk for a fall. On an identified date, after assessment of the resident, the therapist documented two recommendations. During an interview, the therapist confirmed the assessment result documented; however he/she also stated that the home currently does not use this mode of intervention and therefore, the recommendation was not implemented at that time.

On identified dates, the resident was involved in two separate incidents with other residents on the unit; the last incident resulted in the resident being injured. During an interview, PCA #115 and RPN #174 stated that the resident was being monitored closely as forms of intervention which were already set in place prior to the incident. The inspector observed over a period of four days, that the resident was no longer at risk of altercation with other residents because of a change in condition. During staff interviews, PCA #115, RPN #174, and RPN # 176 confirmed that the resident was no longer at risk of altercations with others related to the change in condition.

A review of the resident's written care plan revealed that the home did not implement new or additional interventions or change in strategy when the first incident occurred to prevent the second incident from occurring; except to use the previous strategies which were already set in place prior to both incidents.

Therefore, the licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying triggers for interacting with other residents based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations. [s. 54. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any concerns taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The MOH received an identified complaint on an identified date, related to resident #023 regarding documentation of care provided.

Record review revealed that PCAs did not consistently complete the identified worksheets multiple days over a period of months and some worksheets were missing; and this was applicable to all shifts. The forms also revealed that staff signatures and initials were also missing from all documents.

During interviews, registered staff RN#185 reviewed the documents, confirmed the missing dates and that the document should have been completed daily for each day of the month. During an interview, the Nurse Manager stated that the expectation was for PCAs to complete the special monitoring worksheets for each shift daily, and for each month when in use for a resident. [s. 30. (2)]

2. The MOH received an identified complaint on an identified date, related to resident #002 regarding documentation.

Record review revealed that on an identified date, the resident had a fall and did not sustain an injury; however, the progress notes revealed that the registered staff initiated an identified documentation record. A review of the record revealed that the forms were not completed consistently during the shifts. During an interview, registered staff #174 confirmed that the resident should have been assessed and result documented every hour, then every eight hours for 72 hours. During an interview, the Nurse Manager stated that the expectation was for registered staff to perform and document as noted in the home's policy. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions were taken to meet the needs of the resident with responsive behaviors including assessment, reassessment, interventions, and documentation of the resident's responses to the interventions.

The MOH received an identified complaint on an identified date, related to resident #002 and regarding assessment and documentation of the resident's responses to interventions.

Record review revealed that an identified documentation tool was initiated on an identified date when the resident returned from an acute care hospital; however the forms were not completed consistently by staff during the assessment and observation period and during all shifts. During an interview with registered staff RPN #174 and the Nurse Manager, they both confirmed that the expectation was for PCAs to complete all sections of the form so the interdisciplinary team could use the information to inform treatment decisions. [s. 53. (4) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director had been informed no later than one business day after the occurrence of the an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

The MOH received an identified complaint on an identified date, related to resident #002 in regards to reporting to the Director.

Record review revealed that on an identified date, resident #002 experienced a fall which resulted in injury. The progress notes also revealed that the resident was transferred and admitted to hospital. The home reported the incident on an identified date by using the Critical Incident Report (CIR) system; and not by using the Ministry's method for after-hours emergency contact. During an interview, the nurse manager acknowledged that the report should have been called into the Ministry's after-hours pager system immediately after the incident occurred. [s. 107. (3)]

WN #9: 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:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was being monitored at least every hour while restrained by a member of the registered nursing staff or by another member of the staff as authorized by the registered nursing staff.

The MOH received an identified complaint on an identified date, related to monitoring of resident #002.

On an identified date, the inspector observed resident #002 sitting with a device applied while in the common area. The inspector confirmed the same observation with registered staff RPN #174 and RPN #175; and during an interview both registered staff confirmed that the resident had the device applied. During interviews, registered staff #174 and Nurse Manager #195 confirmed that the hourly monitoring records was not completed for a period of three months in 2016. According to the Nurse Manager registered staff documented on the identified form in specific circumstances as needed. [s. 110. (2) 3.]

2. The MOH received an identified complaint on an identified date, related to monitoring of resident #022.

Record review revealed that there was no documentation in the resident's plan of care to indicate that resident #022 used an identified device. During an interview, registered staff RPN #182, stated that the PCAs would automatically apply the device; and staff further confirmed that the hourly monitoring records were not completed while the the resident was placed in that specific position. [s. 110. (2) 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On an identified date, the inspector observed that registered staff RN #173 opened the door to the medication room and allowed the housekeeping staff to access and clean the room. The registered staff then left the housekeeping staff unattended and unsupervised in the medication room while he/she walked back to the dining room to supervise the lunch meal. There was no other registered staff in the area to supervise the housekeeping staff while he/she was cleaning the medication room. During an interview, registered staff RN #173 apologized and acknowledged that he/she should not have left the medication room unattended while the housekeeping staff was cleaning the room; and also that he/she was balancing priorities because the dining room needed to be supervised during meals. During interviews, registered staff RN #173 and RPN #176 both acknowledged that the medication room door should not have been left opened and unsupervised while the room was being cleaned by the housekeeping staff. [s. 130. 2.]

Issued on this 11th day of July, 2017

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

Original report signed by the inspector.