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
Feb 14, 2017	2017_435621_0005	022974-16, 033166-16	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

BETHAMMI NURSING HOME
63 CARRIE STREET THUNDER BAY ON P7A 4J2

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

JULIE KUORIKOSKI (621)

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): January 23 - 26, 2017.

Follow up inspection #2017_435621_0003 and Critical Incident System (CIS) inspection #2017_435621_0004 were conducted concurrently with this inspection.

Complaint logs that were inspected include:
One intake related to concerns regarding housekeeping, skin and wound management, personal support services, falls prevention and management, nutrition and hydration management, dining and snack service, information for residents on admission and the resident plan of care; and
One intake related to concerns regarding staff to resident abuse, personal support services and skin and wound management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Clerk, Social Worker, Housekeeping staff, Dietary Aides, Food Services Supervisor, residents and family members.

The Inspector also reviewed resident health records, the home's policies and procedures, and investigation notes. Additionally, observations were made by the Inspector of residents, the provision of care and services to residents, as well as staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Snack Observation

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

4 WN(s)
3 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Inspector #621 reviewed a complaint received by the Director during a day in July 2016, which alleged that resident #005 had been found by registered staff during medication rounds to be ingesting a foreign object.

During an interview with the complainant on a specified day in January 2017, they reported to Inspector #621 that this incident occurred during June 2016, and required the resident to be seen for medical evaluation. The complainant reported that PSW staff were to remove from the resident, a specific personal care device at a specific time of day and return this device to the resident at another time of the day, but had not done this prior to the incident.

On a specific day in January 2017, Inspector #621 reviewed resident #005's health care record including documentation dated from a day in June 2016, which identified that RN #114 found resident #005 during medication administration to be ingesting a foreign object. Additionally, on review of a specific section of the resident's care plan dated from April 2016, the Inspector found no information identifying this resident had a specific personal care device and what care responsibilities PSW staff were to follow with respect to application and removal of this resident's personal care device.

During an interview on a specific day in January 2017, RPN #105 reported to Inspector #621 that on a specified date and time in June 2016, registered staff on duty found resident #005 ingesting a foreign object. RPN #105 indicated that it was standard practice for the PSW staff to remove the specific personal care device from the resident prior to care and at other specified times of the day. Subsequently, RPN #105 reported that the personal care device was to be reapplied to the resident as part of their specified care routine at other specific times of the day.

On a specific day in January 2017, RPN #105 reviewed the April 2016, care plan and confirmed to the Inspector that there was no information in the care plan prior to the June 2016, incident identifying this resident had a specific personal care device and what care responsibilities PSW staff were to follow with respect to application and removal of this resident's personal care device.

During an interview on a specific day in January 2017, the DOC identified that it was their expectation that resident #005's plan of care, including the care plan prior to the June 2016 incident set out the planned care with respect to resident #005's personal care device. [s. 6. (1) (a)]

2. 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.

Inspector #621 reviewed a specific number of complaints received by the Director on a specific date in July and November 2016, which alleged that resident #005 was found by a complainant during a visit in the summer of 2016, to have had an area of altered skin integrity with no medical treatment.

During an interview with the complainant on a specific day in January 2017, they reported to Inspector #621 that the area of altered skin integrity was now healed, however they felt staff were not applying a specific therapeutic device they had provided as part of this resident's preventative care plan during specified times of the day.

During interviews with RPN #105 and RN #113 on two specific days in January 2017, they both reported to Inspector #621 that resident #005 previously had an area of altered skin integrity on a certain location of their body and were continuing to use a specified therapeutic device provided by the complainant as a preventative measure during specific times of the day.

On a specific date and time in January 2017, Inspector #621 and RN #113 observed resident #005 without the specified therapeutic device applied.

Inspector #621 and RN #113 reviewed the plan of care, including the written care plan, last revised in January 2017, which identified under a specific focus, that staff were to ensure a specific therapeutic device was applied to a certain area of resident #005's body when out of bed. RN #113 verified to the Inspector that staff had not provided care to resident #005 as per their plan of care.

During an interview with PSW #111, on the same day in January 2017, they informed the Inspector that they had forgotten to apply the therapeutic device to resident #005 that morning as per their plan of care.

During an interview with the DOC and Administrator on a specific day in January 2017, they confirmed to the Inspector that it was their expectation that staff provided care to resident #005 and all residents as per their plans of care. [s. 6. (7)]

3. Inspector #621 reviewed a complaint received by the Director on a specific day in July 2016, which alleged that resident #005 was not provided with nourishment at a specified time of day.

During an interview with the complainant on a specific day in January 2017, they reported to Inspector #621 that they were often in to visit resident #005 at a particular time of day, and found that staff were not offering the resident nourishment prior to a particular activity. The complainant also identified this resident required a specific diet texture offered for all meals and snacks.

During the inspection, Inspector #621 reviewed a copy of the home's scheduled nourishment times, which identified specific times where food and beverages were to be offered to residents between meals.

On a particular day in January 2017, between a specified period of time, Inspector #621 observed resident #005 engaged in a certain activity with no nourishment offered by staff.

On another day in January 2017, between specified periods of time, Inspector #621 observed resident #005 engaged in a certain activity, and no nourishment offered by

staff.

During an interview with RN #113 on a specific day in January 2017, they reported to Inspector #621 that all residents were to be offered a choice of nourishment daily at three specified times between meals.

During an interview on a specific day and time in January 2017, Dietary Aide #106 identified to the Inspector what menu items were available for the specified between meal nourishment. When Inspector #621 inquired what snack from the planned menu was available for a specific modified diet texture, Dietary Aide #106 reported that there was no snack option available for the specified diet texture.

During an interview with Registered Dietitian #104 on a specific day in January 2017, they reported to the Inspector that resident #005 required a specific modified diet texture for both food and fluids.

During an interview with RN #113 on a specific day in January 2017, they reported to Inspector #621 that residents found engaged in a certain activity between mealtimes, were to be also offered between meal nourishment unless a resident's plan of care documented an exception to this standard, and this exception was consented to by the resident and/or their substitute decision maker (SDM).

During an interview with PSW #111 on a specific day in January 25, 2017, they reported to the Inspector that it was the practice of PSW staff in the home to not provide between meal nourishment when residents were engaged in a certain activity, unless a resident's plan of care documented otherwise. With respect to resident #005, it was identified by PSW #111 that this resident usually engaged in the specified activity between meals, and consequently, they would not offer a snack or beverage to the resident during those times. When asked by the Inspector where PSW staff could find information pertaining to this resident's specific care needs, PSW #111 reported that they could locate this information in the resident's chart where a copy of the current written care plan was located.

On the same day in January 2017, PSW #111 reviewed resident #005's written care plan, last revised in January 2017, and confirmed to the Inspector that under a specific focus it was documented that staff were to bring this resident nourishment at meals and between meals, including when the resident was in their room. However, PSW #111 indicated that if this resident was found engaged in a specific activity between meal

times, that they would not disengage the resident from the activity to offer them between meal nourishment during the specified nourishment service times.

During an interview with the DOC on a specific day in January 2017, they confirmed to the Inspector that it was their expectation that staff offered all residents between meal nourishment at the times scheduled in the home, and that residents who engaged in a certain activity during nourishment pass times were to be disengaged from the activity and offered a choice of nourishment, unless otherwise documented in their plan of care. [s. 6. (7)]

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 the planned care for the resident; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the inspection on a specific day in January 2017, between a specified time period, Inspector #621 observed resident #005 engaged in a specific activity, with no snack offered by staff.

During an interview on a specific day and time in January 2017, Dietary Aide #106 reported to the Inspector that for a specified snack time for both the second and third floor resident home areas, specific snack times consistent with the planned menu were brought up with the lunch meal service and kept in the servery refrigerator. When Inspector #621 inquired what snack from the planned menu was available for a specific modified diet texture, Dietary Aide #106 reported that there was no snack option available for the specified diet texture.

During an interview on the same day in January 2017, PSW #107 reported to the Inspector that on the second floor resident home area, resident #005, #008 and #009 required a specific modified diet texture.

Again, on the same day, Inspector #621 reviewed a copy of the diet census for the second floor residents, last revised in January 2017, which documented that resident #005, #008 and #009 required the same modified diet texture for which there was no snack option available at the specified snack time.

During an interview on another day in January 2017, Food Services Supervisor #108 reported to Inspector #621 that it was their expectation that snack items for all texture modified diets were prepared by the cooking staff and available on the resident home areas for snack times as per the planned menu. [s. 71. (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 to ensure that planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #3: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included communication of the seven-day and daily menus to residents.

Inspector #621 reviewed a complaint received by the Director on a day in July 2016, which alleged that resident #005 was not being provided a nourishment consistent with their diet needs between meals. On a day in January 2017, a copy of the home's three week snack menu, with no posted revision date, was reviewed on the second floor menu board by the Inspector. The snack menu identified that a specific menu item was the main afternoon snack choice available for both regular and modified texture options.

During an interview on a specific day and time in January 2017, Diet Aide #110 reported to Inspector #621 that the main afternoon snack choice was a menu item not listed on the snack menu. When asked by the Inspector what the specific texture modified option was, Diet Aide #110 was unsure as there was no label to identify the contents of the container brought up from the main kitchen.

On review of the three week posted snack menu on the second floor menu board, Diet Aide #110 reported to the Inspector that the snack menu posted was not current, and that a specific menu item listed for the specified between meal nourishment was no longer being served as a snack choice.

During an interview on the same day in January 2017, Cook #109 reported to the Inspector that the afternoon snack according to the snack menu posted in the kitchen was a menu item different than what was posted on the second floor menu board.

Inspector #621 reviewed a copy of the three week snack menu as posted in the kitchen, and noted that the afternoon snack choice was as described by Cook #109, was not the menu item identified on the snack menu found on the second floor menu board.

During an interview with the Food Services Supervisor #108, they reported to Inspector #621 that the posted snack menu communicated to residents on the second and third floor menu boards was not the current snack menu, and that revisions to the snack menu had been made in July 2016. Food Services Supervisor #108 confirmed that residents for the past six months were not communicated the current seven-day and daily snack menus. [s. 73. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes communication of the seven-day and daily menus to residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a package of information that complied with the Long-Term Care Homes Act, S.O. 2007, c.8, s.78 was given to every resident and to the substitute decision maker of the resident, if any, at the time that the resident was admitted.

Inspector #621 reviewed a complaint received by the Director on a day in July 2016, which alleged that resident #005 and their Substitute Decision Maker (SDM) were not provided with a copy of the home's admission package until a specified time frame after the admission of resident #005.

During an interview with the complainant on a day in January 2017, they affirmed to Inspector #621 that on admission of resident #005 in the spring of 2016, they did not receive a copy of the home's admission package until a specified time frame after the resident's admission.

During an interview with the Resident Engagement Coordinator on a day in January 2017, they reported to Inspector #621 that at the time of resident #005's admission, they were the staff person responsible for providing a copy of the admission package to the resident or their SDM, if applicable. They confirmed that resident #005 was admitted on a specified day in the spring of 2016, and that a copy of the admission package was not provided to the resident or their SDM until 33 days after admission.

During an interview with Administrator #100 on a specific day in January 2017, they identified that it was their expectation that all residents and their SDM (if applicable) were provided a copy of the home's admission package by the Resident Engagement Coordinator and/or their designate on admission. [s. 78. (1) (a)]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.