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
Oct 18, 2016	2016_246196_0009	010292-16, 010296-16, 011656-16, 012611-16	Complaint

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

LAUREN TENHUNEN (196)

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): July 11, 12, 13, 14, 15, 2016.

The following intakes were inspected: one intake related to sufficient staffing and resident care concerns, two intakes related to resident care concerns and one intake related to staff qualifications.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions and the provision of care and services to residents, reviewed submitted Infoline complaint reports, reviewed the home's written staffing plan and several resident health care records.

This Complaint inspection was conducted concurrently with a Critical Incident System (CIS) inspection # 2016_246196_0011 and a Follow Up inspection # 2016_246196_0010.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), Resident Assessment Instrument (RAI) Coordinator, Housekeeping Aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 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. (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).

Findings/Faits saillants :

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

Inspector #196 observed resident #011 on three particular days during the inspection, to be seated in their wheelchair with a fall prevention device positioned at the side of the chair and not in place across their abdomen.

The health care records of resident #011 were reviewed. The online assessment titled "PASD (Personal assistance service device)" identified the continued use of a fall prevention device as a positioning aide. The progress notes included the same information. The current care plan as found online, noted under the focus of "Risk for falls", the use of a fall prevention device.

On a specific day during the inspection, Inspector #196 conducted an interview with PSW #116. They reported that a restraint was not used for resident #011, but that a fall prevention device was used sometimes that the resident was able to undo if they wanted.

An interview was conducted with #114 Resident Assessment Instrument (RAI) Coordinator and they confirmed that the current care plan did not reflect the use of a fall prevention device as a PASD. [s. 6. (1) (c)]

2. 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.

A complaint was received by the Director related to the repeated room transfers of a resident in the home.

During a review of the health care records for resident #013, Inspector #196 located information related to internal room and bed transfers. The online census in Point Click Care (PCC) indicated that a total of three internal room transfers had occurred over a three month consecutive period in the winter of 2015/2016. The contact information for the Substitute Decision Maker was recorded as the Public Guardian and Trustee (PGT). The progress notes did not indicate whether the resident and or the PGT was informed of the room transfers. In addition, on a particular day during this period, the progress notes identified that resident #013 was found sleeping in their room mates bed, after having being moved from bed one to bed two in the same room. The current care plan identified a memory concern. During the inspection, Inspector #196 approached the resident and they were not interviewable.

The policy titled "Transfer or Discharge" RESI-04-03-02, was reviewed and identified that the registered staff were to discuss the reason for transfer, time of transfer and the new location within facility unit with the resident and family.

On a specific day during the inspection, an interview was conducted with RN #106. They reported that the PGT was not informed of the resident room or bed transfers.

According to the DOC, they had not contacted PGT with regard to the transfers but had a discussion with resident #013, prior to the move, although the resident had a memory concern. [s. 6. (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 that ensures the written plan of care for resident #011 and all residents, sets out, clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During an interview with the DOC during the inspection, they reported six occurrences in a particular month in 2016, in which a registered nurse (RN) was not on duty and present in the home. The DOC stated the normal complement for the home was one registered nurse on both the 12 hours day shift and the 12 hours night shifts and that in the particular month, one registered nurse had resigned, which resulted in short staffing of RNs.

The staffing scheduler #117 provided the "sign in sheets" for the identified particular month in 2016, and identified those hours in which a registered nurse was not on duty and present in the home as follows:

- specific day in 2016 - 0700 to 1900hrs
- another day in 2016 - 0600 to 1500hrs

- another day in 2016 - 0700 to 1500hrs
- another day in 2016 - 0700 to 0800 and 1600 to 1900hrs
- another day in 2016 - 1530 to 1600hrs
- another day in 2016 - 1200 to 1900hrs
- another day in 2016 - 1900 to 0700hrs
- another day in 2016 - 1500 to 1900hrs
- another day in 2016 - 0700 to 1900hrs
- another day in 2016 - 1900 to 0700hrs
- another day in 2016 - 1500 to 1900hrs
- another day in 2016 - 0700 to 1900hrs
- another day in 2016 - 1900 to 0700hrs
- another day in 2016 - 0700 to 1500hrs
- another day in 2016 - 0700 to 1500 and 1830 to 1900hrs
- another day in 2016 - 0700 to 1900hrs
- another day in 2016 - 1900 to 0700hrs
- another day in 2016 - 1500 to 1900hrs

During the inspection, the DOC provided a copy of the written staffing plan dated October 29, 2015, and reported that if they were unable to get a RN to work then the DOC would be available by phone. In addition, they would also call in an extra RPN to act in the role of the registered nurse.

During the inspection, RN #106 provided a copy of a document titled "Registered Nurse Staffing Back Up Plan" dated January 2016. This document read "In accordance with section 31 and 45 of the MOHLTC Long Term Care Act, Birchwood Nursing Home will provide 24 hour Registered Nursing services within the home". It also indicated the procedure for calling in RN staff and also noted "If no registered staff member is able to accept the shift; then a registered practical nurse who is both an employee of the licensee an and member of the regular nursing staff may complete the shift with the provision that a registered nurse is available on call by telephone. (DOC) will be on call".

The home's policy was not in compliance with the legislation O.Reg.79/10,s.45.(1)2(ii) which read:

45. (1) The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and
B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

(2) In this section,
"emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home. [s. 8. (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 that ensures that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with this Act and the regulations; and that the policy was complied with.

Inspector #196 observed resident #014 on a specific day during the inspection, at 0930hrs, to be seated in a wheelchair with a falls prevention device loosely in place across their abdomen. The resident had one hand on the falls prevention device and was observed to pull it away from their abdomen, approximately six inches.

The Inspector confirmed with RN #106 that the falls prevention device was a restraint and it was an improper fit as it was loose on the resident's abdomen. They proceeded to attempt to tighten the falls prevention device across the resident's abdomen.

During a health record review, Inspector #196 found that the current care plan indicated that resident #014 had a specific type of falls prevention device as a physical restraint for safety. The restraint record for July 2016 was reviewed and identified the use of a specific falls prevention device for safety. The restraint record did not include documentation of the application of the falls prevention device the morning of the observations on July 15, 2016, nor the safety checks from the time of application to the time of observations at 0930hrs.

The home's policy "Restraints - Physical/Mechanical" policy number 08-10-02, dated May 2010, was reviewed by Inspector #196. The policy indicated "Restraints must be applied according to manufacturer's specifications. Once applied the restraint should be comfortable for the resident and support their safety". In addition, the policy noted "Hourly checks should be completed and documented to ensure the resident's comfort and security and to confirm that the restraint remains positioned and applied correctly". [s. 29. (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 that ensures the written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #4: 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 for the personal support services program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Two complaints were received by the Director which outlined concerns with staffing in the home and care not provided to residents as required.

On a specific day during the inspection, Inspector #196 and the DOC reviewed a document which outlined the home's evaluation of the nursing and PSW staffing services, dated May 2016.

The DOC confirmed to the Inspector that the staffing plan for the personal support services program was not evaluated annually with evidence-based practices, except to identify the normal PSW complement that were assigned to each unit on each shift. [s. 31. (3)]

2. 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 and that met the requirements set out in the Act and this Regulation.

Two complaints were received by the Director which outlined concerns with staffing in the home and care that was not provided to residents as required.

On a specific day during the inspection, Inspector #196 conducted an interview with the DOC regarding the home's current staffing plan. The DOC reported that the normal staffing complement for the home was four PSWs on each floor on day and evening shifts and two PSWs on each floor on the night shift, one RN on twelve hour day and twelve hour nights shifts, and one RPN on each floor on both day and evening eight hour shifts and no RPNs on the night shift.

The DOC reported that the majority of time, three PSWs worked on each day and evening shift on each unit, not the four PSW as per the staffing plan. Inspector #196 reviewed the home's resident census which indicated that 92 residents resided in the home at the time of the inspection.

On a specific day during the inspection, at 1810hrs, an interview was conducted with RN #118. They reported that the evening shift was working with 50 percent of the PSW staffing complement on each unit, or two PSWs per unit, but that one additional RPN would work until 1900hrs to help out.

An interview was conducted with PSW #119 at 1825hrs, that same evening, regarding the staffing compliment. They reported that there was only two PSWs working on that particular floor. They stated that eight residents were scheduled to have a tub bath or shower that evening but they would be provided with a bed bath, despite their

preference.

Inspector #196 reviewed the home's contingency plan for working with less PSWs than the staffing complement outlined. The plan noted that residents scheduled for bathing during the evening would be provided with bed baths in place of a tub bath or shower.

The following day, at 1510hrs, RN #106 identified that resident #015, #016, #017, #018 and #019 had been listed on the bathing schedule for that specific floor for the previous evening shift. Inspector #196 reviewed the PSW flow sheets for the previous evening, for each of these residents and they did not indicate that bathing or nail care had been provided to these residents.

Inspector #196 interviewed PSW #103 who confirmed that tub baths or showers were not provided to the residents of that specific floor during the evening shift of the particular day.

Again, on the following day, at 1520hrs, RN #106 identified that residents #020, #021, #022, #023, #024 and #025 had been listed on the bathing schedule for the other floor for the previous evening shift. Inspector #196 reviewed the PSW flow sheets for the previous evening, for each of these residents and they did not indicate that bathing or nail care had been provided to these residents.

Inspector #196 interviewed PSW # 116 who confirmed that tub baths or showers were not provided to the residents of that specific floor during the evening shift of the particular day.

On a specific day, Inspector #196 and RN #106, made observations of some of the residents on both the floors that had been scheduled for tub baths or showers the previous evening but had not been provided to them. Resident #020 had heavily soiled finger nails and was unshaven and resident #021 had greasy, soiled hair. Resident #022 had a strong odour of feces and body odour and looked unkempt. Resident #023 was questioned regarding a bath the previous evening and stated that they had not been offered a bath. Resident #024 had greasy hair and resident #016 had heavily soiled finger nails and food debris covered clothing. Resident #018 was unshaven.

RN #106 acknowledged that the several of the observed residents were ungroomed, had not had nail care and some were unshaven.

Inspector #196 reviewed the home's policies regarding bathing and nail care. The policy titled "Nail and foot care" RC-08-01-04 last updated June 2016, read "All residents will have their fingernails/toenails and feet checked at the time of their bath/shower and care provided according to their needs and preferences".

The policy titled "Activities of Daily Living" subject "bathing", RESI-05-07-23 last revised August 2005, read "All residents will be offered a minimum of two baths per week. Additional baths may be required as determined by the hygiene requirements of the resident. For the purposes of this policy, a bath means a tub bath, shower, or complete bed bath, including foot care, cleaning and trimming of fingernails and toenails, and oral hygiene."

The policy titled "Bathing , Showering and Water Temperature Monitoring", RC-08-01-02, last updated June 2016, read "all residents will be provided with personal, individualized bathing which will be a comforting, relaxing, stress-free experience that respects personal choice, dignity and privacy" and "residents will be offered a tub bath or shower, based on resident preference, twice per week, at minimum. The bathing will occur by the method of the resident's choice and may occur more frequently, as determined by the resident's hygiene requirements." and "For the purposes of this policy, "bathing", includes tub baths, showers and full body sponge baths using evidence-based person-centred techniques from Bathing without Battle. " [s. 31. (3)]

3. The licensee has failed to ensure that the staffing plan must, provide for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation.

On a specific day during the inspection, Inspector #625 observed resident #008's washroom call bell ringing. During a discussion with resident #008 about the call bell, the resident stated that they required assistance from staff to use the washroom as they required the use of an apparatus. The resident also stated that they often waited for long periods of time for staff to respond to assist them to use the washroom.

At 1831hrs, Inspector #625 observed RPN #111 respond to resident #008's washroom call bell and shut it off. The Inspector heard the RPN tell the resident that they could not assist the resident with toileting, as they required a second staff person to do so, and would have to wait for staff to be available to assist them.

At 1838hrs, the Inspector observed resident #008 to continue to wait for assistance from

staff with toileting.

At 1850hrs, the Inspector observed that the call bell to the resident's washroom was again ringing. Residents #008 and #009 informed the Inspector that resident #008 was still waiting to use the washroom and resident #009 now also needed to use the washroom.

During an interview with Inspector #625 on that same evening, resident #009 (resident #008's roommate) stated that resident #008 waited for a long time for staff to respond to the resident's call bell and/or to assist the resident to use the washroom. Resident #009 shared a room with resident #008 and stated that, at times, resident #009 had observed resident #008 wait for up to one hour for staff assistance with toileting.

During an interview with Inspector #625 on that same evening, PSW #103 stated that resident #008 did not have to wait to use the washroom when the floor was fully staffed, but had to wait when the floor was working short. The PSW stated that the floor was working short that evening, as two PSWs were working instead of four. PSW #103 stated that the resident may wait up to 30 minutes for assistance with toileting when the floor had less than the full complement of PSWs working.

A review of resident #008's current care plan by Inspector #625 identified goals that the resident would receive necessary assistance and be clean, dry and odour free. Interventions listed included two staff assistance for the entire process of toileting, that staff were to use an apparatus, and that staff were to toilet the resident as per their request.

During an interview with Inspector #625 on a day during the inspection, the Acting DOC #106 stated that resident #008 required the assistance of two staff with toileting and would request the assistance from staff when they needed to use the washroom. The Acting DOC #106 also stated that staff should respond as soon as possible to assist the resident to the washroom at the resident's request, and that the resident should not have to wait for 30 minutes for assistance after they requested assistance. The Acting DOC #106 commented that the resident had to wait for 30 minutes to be toileted during the evening of a particular day, as a result of the floor being short staffed, and staff not being able to provide assistance to the resident when they requested it. [s. 31. (3)]

4. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the

staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

On a particular day during the inspection, RN #106 provided a document titled "Registered Nurse Staffing Back Up Plan" to Inspector #196. The document noted: "In accordance with section 31 and 45 of the MOHLTC Long Term care act, Birchwood Nursing Home will provide 24 hour Registered Nursing services within the home". The plan identified that "in the event a scheduled Registered Nurses cannot complete her scheduled shift, the home will offer the shift to other registered staff" and "If no registered staff member is able to accept the shift; then a registered practical nurse who is both an employee of the licensee an and member of the regular nursing staff may complete the shift with the provision that a registered nurse is available on call by telephone. (DOC) will be on call".

An interview was conducted with the DOC and they reported that an emergency was when a RN calls in sick to work and the home is unable to replace them then the DOC would be available by phone, an extra RPN would be called in and have them act in the role of a RN.

The home's policy was not in compliance with the legislation O.Reg.79/10,s.45.(1)2(ii) which read:

45. (1) The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

2. For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

i. in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works at the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and
B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

(2) In this section,
"emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home. [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 that ensures that the staffing plan for the personal support services program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this Regulation and the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a

minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On a particular evening shift, during the inspection, both floors were staffed at 50 percent PSW staffing complement as reported by RN #118.

Inspector #196 reviewed the home's contingency plan for working with less PSWs than the staffing complement outlined. The plan noted that residents scheduled for bathing during the evening would be provided with bed baths in place of a tub bath or shower.

During an interview with RN #106, a review of the PSW flow sheets for the residents listed on one of the floors bathing schedule for the previous evening was reviewed. RN #106 acknowledged that there was no documentation to indicate that any of the residents scheduled for tub baths or showers, specifically resident #015, #016, #017, #018, and #019, had received them. In addition, during that one week time period, each of the identified residents had only one bath documented in the flow sheets as being provided.

Inspector #196 interviewed PSW #103 who reported no tub baths or showers were provided to the residents of the floor, the previous evening shift.

During an interview, RN #106 stated that residents #020, #021, #022, #023, #024 and #025 were scheduled for tub baths or showers, as listed on the floor bathing schedule, the previous evening. RN #106 acknowledged that there was no documentation to indicate that any of the residents scheduled for tub baths or showers, specifically resident #020, #021, #022, #023, #024 and #025, had received them. In addition, during that one week time period, each of the identified residents had only one bath documented in the flow sheets as being provided.

During an interview with Inspector #196, PSW #116 confirmed that none of the residents listed on the bathing schedule for the previous evening, received tub baths or showers, because only two PSWs were working.

During an interview with the DOC, they stated that missed baths were to be listed on the 24 hours shift report so that an additional staff member would be brought in the following day to provide the baths. Inspector #196 reviewed the 24 hours shift report from the particular evening, which did not list any tub baths or showers had not been provided and needed to be completed. In addition, the DOC confirmed that an additional staff member

was not brought in to provide the missed baths.

Inspector #196 reviewed the home's policies regarding bathing. The policy titled "Activities of Daily Living" subject "bathing", RESI-05-07-23 last revised August 2005, read "All residents will be offered a minimum of two baths per week. Additional baths may be required as determined by the hygiene requirements of the resident. For the purposes of this policy, a bath means a tub bath, shower, or complete bed bath, including foot care, cleaning and trimming of fingernails and toenails, and oral hygiene." An additional policy titled "Bathing , Showering and Water Temperature Monitoring", RC-08-01-02, last updated June 2016 read "residents will be offered a tub bath or shower, based on resident preference, twice per week, at minimum. The bathing will occur by the method of the resident's choice and may occur more frequently, as determined by the resident's hygiene requirements." [s. 33. (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 that ensures each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

A complaint had been received by the Director related to the provision of care to resident #011, specifically no daily shave.

During the inspection, on a particular day, at 1655hrs, resident #011 was observed to have their facial hair unshaven.

The health care records for resident #011 were reviewed for information regarding hygiene care and grooming needs. The current care plan under the focus of "Hygiene/Grooming" included the intervention of "staff to shave daily". The daily care flow sheets, over a five day period, did not contain documentation of the care provided, specifically shaving, on any of these days and there was no documentation of resident refusal to be shaved.

The home's policy titled "Daily Personal Care and Grooming", RC-08-01-01, June 2016, was reviewed and indicated that "A.M. personal care" included shaving.

During the inspection, Inspector #196 conducted an interview with the DOC. They reported that the expectation was that staff were to document in the flow sheets, the care that was provided to a resident and to they were to initial the bottom of the sheet. [s. 32.]

Issued on this 19th day of October, 2016

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

Original report signed by the inspector.