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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Nov 5, 2015	2015_389601_0022	O-002658-15	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BON AIR RESIDENCE
131 Laidlaw Street South Cannington ON L0E 1E0

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

KARYN WOOD (601), PATRICIA MATA (571), SAMI JAROUR (570), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 19-23, 2015 and October 26-30, 2015.

During the course of the inspection 2 Critical Incident Inspections were completed, Log #O-002922-15 and O-002951.

During the course of the inspection, the inspector(s) spoke with Residents, Family, Resident Council President, Family Council President, the Physician, Dietitian, Food Service Supervisor, Program Support Services Manager, Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN),Dietary Aides, Housekeeping staff, Maintenance Manager, Assistant Director of Care (ADOC)/RAI Coordinator and the Administrator/Director of Care.

During the course of the inspection, the inspector(s) toured the home, observed dining and nourishment service, observed staff to resident interaction during the provision of care, observed medication administration pass, reviewed the minutes of the Resident Council and the Family Council meetings, the Quality Improvement records, observation of infection control practices, observed residents in activities. Reviewed the licensee's policies related to Abuse, Skin and Wound, PASD-Bed Rails, Resident Falls, Continence Care and Responsive Behaviours. Reviewed the licensee's internal investigation related to critical incidents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **2 WN(s)**
- **2 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. (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. (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. Related to Log#O-002922-15

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

Resident #001 had fallen four times over a six month period and had been identified as a high risk for falls. Resident #001 sustained an injury on an identified date as a result of the fall.

On an identified date and time resident #001 indicated to Inspector #623 to not being able to reach the call bell. Inspector observed that the call bell cord was tied to the bottom of the bed rail and a pillow was placed between the resident and the bed rail in a way that resident #001 could not see it.

Resident #001's call bell was activated by Inspector #623 and when it alarmed PSW#102 was in the hallway and entered the room. PSW#102 indicated to Inspector #623 that resident #001 needed to get up because resident #001 was restless and had been ringing the bed alarm and call bell. PSW #102 indicated that resident #001 was always pulling the call bell, the bed alarm or unclipping the alarm, therefore the call bell had been moved so that resident #001 couldn't reach it.

Review of resident #001's current plan of care indicated that resident #001 was a high risk for falls and the call bell is to be clipped to resident #001's clothing when in bed. On an identified date and time the call bell was not clipped to resident #001 clothing when in

bed, therefore care was not provided as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure in that when resident #006 was reassessed,and care plan interventions noted not to be effective, no different approaches were considered in regards to weight loss.

Resident #006's weight on an identified date was 59.0 kg. On another identified date, weight was 46.6 kg. Therefore, resident #006 lost 12.4 kg over five months. The consumption record for meals indicated that for an identified month, resident #006 refused 26 meals out of 24 days. Of the meals consumed, resident #006 consumed 26-50 percent of 24 meals and 0-25 percent of 20 meals. Resident #006 was ordered a dietary supplement after every meal five months prior and continued to have weight loss.

In an interview, the Registered Dietitian indicated that resident #006's dietary supplement three times a day had not been increased because staff had indicated that resident #006 refuses to drink the dietary supplement currently ordered or does not drink it all. RPN #107 who works full time on the day shift indicated that resident #006 rarely refuses the dietary supplement offered after meals.

A review of the electronic Medication Administration Record over a three month period indicated that resident #006 refused the dietary supplement eleven out of ninety three occasions on an identified month, refused the dietary supplement on nine out of ninety occasions on another identified month and on four out of seventy-two occasions just over a three week period.

In an interview, PSW#106 indicated that resident #006 has responsive behaviours in relation to eating. When this occurs, staff will move resident #006 to another location to sit alone. In an interview, RN #108 indicated that no other interventions have been attempted at meals except for removing the resident to another location, if disruptive behaviours are occurring.

During an observation by inspector #571 on an identified date, resident #006 ate some soup then pushed it away. PSW #116 offered resident #006 a plate with both choices on it and the resident declined. PSW #116 later indicated that the resident indicated not liking the soup or lunch choices. No other food observed being offered. The resident continued to sit quietly at the table while the resident's table mates continued eating their meals.

The plan of care for resident #006 directs staff to provide intermittent assistance with eating and lots of encouragement. When resident #006 shows behaviours at meal time and staff are to remove resident #006 from the table; this intervention was added by the Behavioural Support Team approximately three months prior. The dietary supplement was added after every meal five months prior to ongoing weight loss.

Therefore, the Dietitian did not revise resident #006 plan of care when the resident was identified as having weight loss. RPN#107 and RN#108 did not reassess resident #006's plan of care interventions when not effective as observed and reported by the PSWs. The registered staff and the Dietitian did not consider other interventions even though resident #006 continued to have weight loss. [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 resident #001 has access to the call bell as specified in the plan and that when resident #006 is reassessed and care needs changed that the plan of care is reviewed and revised, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their policy LTC-CA-WQ-200-08-03 titled Wound

Care Treatment revised on an identified date was complied with.

O. Reg 79/10, s.48(1) states the licensee shall ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions are developed and implemented in the home.

Policy LTC-CA-WQ-200-08-03: Wound Care Treatment, revised on an identified date:

Indicated under the title "Policy":
Residents with altered skin integrity and current wound care will have their plan assessed weekly, with weekly wound care reassessment. Residents with stage 2 and higher pressure ulcers will have their wounds reassessed weekly by the home's skin care coordinator.
An "Ont- Skin and Wound Assessment" will be initiated when there is an alteration in a resident's skin integrity. This record is to be completed weekly by registered staff and is used to document specific information regarding pressure sores and wounds as well as the treatment and healing of the affected areas.
Residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will receive:
-a skin assessment by a member of the registered nursing staff using the "Pressure Sore Risk Assessment", in PCC
-immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection
-a referral to the Registered Dietitian

A review of resident #014's clinical records indicated that on an identified date the Physician ordered a medication three times a day for two weeks to treat resident #014's deteriorating skin condition. A documented skin and wound assessment was completed for resident #014 on an identified date, eight days following the initiation of the medication. On an identified date, a documented skin and wound assessment was completed for resident #014, almost seven weeks following the prior assessment. At this time, the Physician indicated that resident #014's skin condition had been improving with the prior course of medication and the routine treatments, but resident#014's skin condition had become inflamed and required another course of medication. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of resident #019's clinical records indicated that on an identified date the

Physician documented that resident #019 had developed skin breakdown. A documented skin and wound assessment was completed two days after the skin breakdown was identified by the Physician. A review of the progress notes indicated that resident #019's treatment had been completed on three different occasions during an identified month, but there was no documented skin and wound assessment for resident #019 until twelve days following the prior assessment. At that time, the Physician indicated that resident #019's skin breakdown had deteriorated. [s. 8. (1) (a),s. 8. (1) (b)]

3. A review of resident #016's clinical records indicated that resident #016 had skin breakdown. The records for a three month period were reviewed. A documented skin wound assessment was completed on an identified date. A weekly skin assessment was missing for two identified weeks during the month identified. A documented skin and wound assessment was completed for resident #016, seven days following the deteriorating skin breakdown, and twenty days following the prior skin and wound assessment.

In an interview, RPN#107 indicated that a weekly wound assessment should be completed under assessment in Point Click Care (PCC) in the computerized documentation or in the progress notes in PCC.

Therefore, the licensee failed to ensure that the staff documented weekly skin assessments for resident #014, #019, and #016 as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy LTC-CA-WQ-200-08-03 titled Wound Care Treatment is followed for resident #014, #019, and #016 related to documentation of weekly wound assessments, to be implemented voluntarily.

Issued on this 12th day of November, 2015

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

Original report signed by the inspector.