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
Jun 26, 2015	2015_214146_0010	H-002691-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD BURLINGTON ON L7P 5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD BURLINGTON ON L7P 5A6

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

BARBARA NAYKALYK-HUNT (146), CAROL POLCZ (156), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11, 12, 15, 16, 17, 18, 19,22, 2015 and H-2765-15 + 2 Nov 3/15

Concurrently with the RQI, Critical incident inspection #004622-15, Inquiry #006477-15 and Follow-up #009363-15 were inspected.
During the course of the inspection, the inspectors: toured the home; reviewed policies and procedures, the home's internal notes, resident health records, documentation related to bed and bedrail safety, meeting minutes; and observed residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Nursing Officer, Director of Care (DOC), Resident Assessment Instrument (RAI) Minimum Data Set (MDS) coordinator, Recreation Manager, registered staff, dietary staff, Personal Support Workers (PSW's), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
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
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

10 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_189120_0027	146

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a date in March 2015, an identified resident exhibited responsive behaviours toward an identified Personal Support Worker (PSW). An internal investigation was completed and it was concluded that the identified PSW did not respond in a manner that treated the resident with dignity and respect.

The Chief Nursing Officer and Director of Care confirmed this information. [s. 3. (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 following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The current plan of care and latest MDS assessment dated in April 2014 for an identified

resident indicated that the resident was to receive pudding thickened fluids. The dietary serving notes and current physician's diet order indicated that the resident was to receive honey thickened fluids. Progress notes dated December 19, 2014 indicated that the Registered Dietitian (RD) had changed the fluid consistency to pudding thick. During the lunch meal observation on a date in June 2015, the resident received a thickened drink that was at a nectar-honey consistency. This product was thickened by registered staff and when the inspector intervened, the supplement was thickened further. There was also a labelled pudding thickened drink on the table for the resident. Staff spoken to reported that they were unsure of what consistency to provide to the resident. The plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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

A review of the clinical record for an identified resident indicated, on their admission Resident Assessment Protocol (RAP)completed by a Recreation aide, that they liked to be involved in the activities that were provided in the facility and their goal was to maintain their current level of activity in the home. The plan of care however, completed by the Recreation Manager for the same time period, indicated that the resident had an alteration in their supervised/ organized recreation activities that was characterized by little or no involvement and lack of attendance. An interview with the Recreation Manager confirmed that they had not collaborated with the recreation aide in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

3. 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) On a date in June 2015 an identified resident fell without injury. The resident's Power of Attorney (POA) was not notified of the fall and was not given the opportunity to participate fully in the development and implementation of the resident's plan of care. The DOC and a registered staff member confirmed that the POA of the resident was not notified of the fall.

B) On a date in May 2015 an identified resident fell without injury. The resident's POA was not notified of the fall and was not given the opportunity to participate fully in the development and implementation of the resident's plan of care.
The Chief Nursing Officer and a registered staff member confirmed that the POA was not notified of the fall. [s. 6. (5)]

4. 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.

A) The plan of care for an identified resident indicated that the resident was to be provided with specific sized portions of food and a supplement at the end of all meals. During the observed lunch meal on a date in June 2015, the resident was not provided with the specific sized portion or the supplement as confirmed with the front line staff. (156)

B) An identified resident's plan of care dated February 2015 indicated that the resident was to be transferred with two staff members with a mechanical lift. The plan of care also identified that if the resident refused to use the mechanical lift this was to be reported to the registered staff.
On a date in March 2015 an identified PSW did not follow the specified plan of care and transferred the resident alone using the mechanical lift.
The Chief Nursing Officer and DOC confirmed that the care provided to the resident was not provided as specified in the plan of care. (611)

C) Review of an identified resident's plan of care and care conference notes dated April 2015, revealed that the resident was to participate in specific programs. This was confirmed by the Recreation Manager. Review of the activity attendance check sheets for April, May and June 2015 and the sign in book revealed that there was no documentation for the specific programs. This was confirmed by registered staff. The Recreation Manager confirmed that the specific programs/interventions had not been provided for the resident as set out in the plan of care. (510) [s. 6. (7)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan had not been effective.

An identified resident's admission plan of care indicated that the resident had little or no

involvement and a lack of attendance in organized recreational activities in the home. A review of the activity attendance documentation sheets, that were completed by the recreation aides, indicated that the resident had a further decrease in the participation and increase in the number of refusals to attend activities within the home over the past six months. There was no change or revision in strategies/interventions in the plan of care since admission even though the interventions were ineffective. The residents rate of refusals for activities in 2015 was documented as; January- four refusals, February-six refusals, March -14 refusals, April- 17 refusals, May - 18 refusals. Interview with the Recreation Manager confirmed that the resident had not been reassessed and their plan of care reviewed and revised when the care set out in the plan had not been effective. [s. 6. (10) (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 s.6(5) 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 and s6(7) 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 #3: 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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A review of an identified resident's clinical record indicated that in January 2015 the resident was observed to have a wound. A skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was not completed until February 2015 using the home's Wound Assessment (V.1) form. Interview with the DOC confirmed that the home had not completed a skin assessment using a clinically appropriate assessment instrument (ie the home's Wound Assessment (V.1) form) when the resident exhibited the wound in January 2015.[s. 50. (2) (b) (i)]

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

A) A review of an identified resident's clinical record indicated that the resident had a wound in January 2015. Further review of the clinical record indicated inconsistent use of the home's Wound Assessment (V.1) form for completing weekly wound assessments. Ten weekly wound assessments were not completed between January 1 and end of May 2015. Interview with the DOC confirmed that the resident's wound had not been reassessed at least weekly by a member of the registered staff.

B) In December 2014 an identified resident was assessed to have a wound. A review of the health record indicated that only four (4) of 18 weekly skin assessments were completed by registered staff. The DOC confirmed that the registered staff did not reassess the resident's wound weekly. (611) [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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (a) could be easily seen, accessed and used by residents, staff and visitors at all time.

During stage one of the inspection, on a date in June 2015, the bed of an identified resident did not have a call bell communication and response system that could be activated as confirmed with front line staff. [s. 17. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

The MDS assessment, section H1a (bowel continence), completed in May 2015 for an identified resident, indicated a change from continent to occasionally incontinent. Review of the point of care (POC) documentation for the resident revealed that the resident was incontinent of bowel during the MDS assessment period and continued to be incontinent of bowel in June 2015. Registered staff confirmed that the resident remains incontinent.

Review of the current plan of care revealed that there was no direction in the clinical record for management of the bowel incontinence such as toileting on a regularly scheduled basis according to the resident's individual needs. The DOC confirmed that this resident, who became incontinent of bowel, did not have an individualized plan of care to promote and manage bowel continence. 510 [s. 51. (2) (b)]

2. The licensee failed to ensure that, (g) residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

On a date in June 2015 an identified resident was observed at 0930 in the entrance way of the home. The resident was observed to be wet in the front groin area of their pants and had an odour of urine. A PSW was observed to come and assist the resident back to the unit. When the resident was again observed on the unit 15 minutes later there was a larger wet area in the groin area of their pants.
The RPN was notified and confirmed that the resident was not dry and had not been changed to ensure they were clean dry and comfortable. The resident was immediately assisted to the bathroom to be changed by a PSW. [s. 51. (2) (g)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The home did not provide education with respect to the Residents' Bill of Rights and the long term care home's policy to promote zero tolerance of abuse and neglect of residents to the hairdressers providing services to residents in the home. An identified hairdresser confirmed that this education was not provided for a period of twenty (20) years. In addition, the home was not able to confirm whether this education was provided to other contracted services.
The Chief Nursing Officer and the Recreation Manager confirmed the above information. [s. 76. (4)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.
The required information for the purposes of subsections (1), were not observed to be posted in the home on a date in June 2015 during the initial tour of the home during the home's RQI:
(a) the Residents' Bill of Rights; (b) the long-term care home's mission statement; (c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; (d) an explanation of the duty under section 24 to make mandatory reports; (e) the long-term care home's procedure for initiating complaints to the licensee; (f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; (g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; (g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network; (k) copies of the inspection reports from the past two years for the long-term care home (5 inspection reports were required and only two were observed to be posted); (n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; (o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; (p) an explanation of the protections afforded under section 26; and (q) any other information provided for in the regulations.
The home had a small family information board located at the front entrance of the home that did not contain the above information. A tour of the home and interview with the Administrator confirmed the licensee failed to ensure the required information was posted in the home. [s. 79. (1)]

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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

On a date in April 2015, Public Health declared an outbreak at the Home. The home did not immediately submit a critical incident (CI), as confirmed by the DOC.

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

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff applied the physical device in accordance with any manufacturer's instructions.

On a date in June 2015, a resident was observed to be in a chair with a device that was improperly applied. Interview with the RPN confirmed that the device was not applied according to the manufacturer's instructions. [s. 110. (1) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Review of the Infection Prevention and Control Program revealed the absence of a written record of the annual evaluation of the Infection Prevention and Control Program. The Chief Nursing Officer confirmed that a written record of the program evaluation was not kept for 2014. [s. 229. (2) (e)]

Issued on this 3rd day of July, 2015

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

Original report signed by the inspector.