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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 4, 2014	2014_188168_0019	H-001136-14	Resident Quality Inspection

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

LISA VINK (168), CAROL POLCZ (156), CYNTHIA DITOMASSO (528), JENNIFER ROBERTS (582)

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): August 25, 26, 27, 28, 29, 2014, and September 2, and 3, 2014.

Critical Incident Inspection log number H-004039-14 was completed concurrently with this RQI inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DOC), Director of Quality Outcomes (DQO), Director of Programs and Services, Director of Dietary/Environmental, maintenance staff, Director of Policy and Legislation, Personal Support Workers (PSW), Registered Nursing staff, dietary staff, Registered Dietitian (RD), families and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, reviewed relevant documents including but not limited to: policies and procedures, meeting minutes, and clinical health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care
Snack Observation

Findings of Non-Compliance were found during this inspection.

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. (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).

Findings/Faits saillants :

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

Resident #31 was noted in the August 16, 2014, Minimum Data Set (MDS) assessment, to be at high nutritional risk and high risk for choking. The resident was not meeting their fluid requirement and was deemed to be at moderate risk for dehydration. The assessment indicated that dehydration/fluid maintenance would be care planned with the goal to maintain hydration; however; the plan of care did not include a focus statement related to hydration. As confirmed with the DOC and Director of Dietary on September 3, 2014, the planned care for resident #31 in relation to hydration was not included on the care plan. [s. 6. (1) (a)]

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

The plan of care for resident #21 indicated they required a tilt wheelchair for positioning and comfort. From June 2013, to present, the quarterly MDS assessments under "Devices and Restraints" indicated they used a chair that prevented rising daily, on three assessments, and as not used on two other assessments. Interview with the DQO confirmed that the resident's condition had not changed since June 2013; however, the quarterly MDS assessments were not consistent with each other in relation to the use of devices and restraints. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home's Skin Care Management Program, reference number 006020.00, last revised June 2013, indicated:
-registered staff to complete the Head to Toe Skin Assessment Tool when a resident returned from hospital after greater than eight hours
-when a resident exhibited altered skin integrity registered staff were to initiate a referral to the dietitian for any changes to skin integrity;
-the dietitian was to complete a nutritional assessment within seven days.

i. In 2014, resident #21 exhibited a new area of altered skin integrity, which was immediately assessed by registered staff and referred to the RD. Review of the plan of care 13 days later did not include an assessment by the RD. Interview with the RD on August 27, 2014, confirmed that the resident had not been assessed but planned to complete that day. The resident was not assessed within seven days from the RD referral as outlined in the program.
ii. In 2014, resident #31 returned from a three day hospitalization. A review of the clinical record did not include a completed Head to Toe Assessment Tool in Point Click Care (PCC), as outlined in the program. Interview with the DOC confirmed the Head to Toe Assessment Tool was not completed after the resident returned to the home from hospitalization. (528)

B. The home's Fall Prevention Management Program, reference number 005190.00, effective date August 13, 2013, indicated that all high risk fallers were to be identified through a list and a symbol of a falling leaf for each resident be placed in an area visible to staff. The DOC confirmed the expectation was that the falling leaf be placed on the top of the resident's doorway for those deemed to be high risk fallers.

A review of the clinical record for resident #22 revealed that they were identified to be at high risk for falls according a Post Falls Assessment completed. On September 2, 2014, there was no falling leaf symbol present on the resident's doorway which was confirmed by a PSW staff. The home did not comply with their falls prevention policy. (582)

C. The home's Pain Assessment Program, reference number 005300.00, effective date June 3, 2011, identified that "each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes".

Resident #30 was identified to experience no pain during the MDS Quarterly assessment of December 7, 2013, and mild pain daily on the March 8, 2014, MDS assessment. The last formalized pain assessment completed in the resident's record was dated June 21, 2013, as confirmed with the DQO. Interview with the DQO confirmed that the resident should have been assessed using a formalized assessment tool or seven day pain progress notes and then a summary note completed due to the change in pain, which was not completed. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a
resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Section 33(4) of the Long Term Care Homes Act identified that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with the authority to give consent.

It was observed on August 25 and 26, 2014, that residents #26 and #33 were seated in wheelchairs tilted in a reclined position. Review of the plans of care for both residents indicated they used the tilt wheelchairs as PASD's, but did not include formal consents for the use of the tilt feature. Interview with the DQO confirmed that the resident's used the tilt wheelchairs for safety and positioning daily and consent for the use of the PASD's was not documented in their plans of care. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration implemented.

A. In 2014, resident #27 had a new area of altered skin integrity as documented by registered staff. Review of the record did not include an assessment by the RD in relation to the altered skin integrity. Interview with the RD identified a referral was not created related to the altered skin integrity and therefore an assessment was not completed. [s. 50. (2) (b) (iii)]

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

A. In summer 2014, registered staff documented a new area of altered skin integrity for resident #21. Review of the clinical record did not include a weekly wound assessment from August 24, 2014, to September 1, 2014. Interview with registered staff on September 2, 2014, confirmed that a weekly assessment was not completed during the identified time period. (528)
B. In summer 2014, registered staff documented a new area of altered skin integrity for resident #27. A review of the clinical record did not include a weekly assessment after the initial assessment. Interview with registered staff confirmed that the weekly wound assessments were not completed after the initial assessment of the wound. (528)
C. Resident #28 was observed to have two dressings on August 25, 2014. According to the clinical record the resident had ongoing issues with altered skin integrity in the identified areas. The areas were not reassessed weekly by a member of the registered nursing staff. A reassessment of the areas were documented on June 10, 2014, again June 26, 2014, and then not again until July 15, 2014. Interview with the DOC confirmed the expectation that the areas be reassessed weekly and that they were not completed as required. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home had a dining and snack service that provided residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On August 25, 2014, at 1415 hours, resident #31 was observed in bed with a lunch meal tray on their bedside table. Two of the tray items had not been opened and less than twenty percent of the tray was gone. Both the resident and family indicated that the resident had not yet finished eating when the PSW had to leave and that the PSW did not return to provide the care assistance required.
A review of the plan of care indicated that the resident required supervision to total dependence for eating related to physical limitation.
Interview with the PSW confirmed that they attempted to assist the resident with eating lunch that afternoon and then left the room and confirmed that they did not return to feed the resident their lunch, nor did they notify evening staff of the need to complete.
Interview with DOC confirmed he was aware that the PSW left the resident's room during the meal, however, the expectation was they returned to finish with feeding the resident.
Interview with evening staff at 1440 hours, indicated that they were unaware that the resident had not been provided with assistance to complete their lunch meal and that they would attempt to assist the resident after initial shift round.
At 1445 hours, the lunch tray remained in the room and the resident had yet to be provided assistance to finish their lunch meal. [s. 73. (1) 9.]

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 dining and snack service provides residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment was maintained in a good state of repair.

The home had a spa room with a tub that was not maintained in a good state of repair. The shower head, which was positioned into the basin of the tub, was observed on August 29, 2014, and September 2, 2014, to leak water which pooled near the drain, even after all taps were tightened, and sufficient time allotted to drain. Discussion with maintenance staff confirmed that the tub had pooling of water from the shower head and identified that an outside vendor would most likely be required to repair the concern. [s. 15. (2) (c)]

WN #7: 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 did not ensure that the resident received individualized personal care, including hygiene care and grooming on a daily basis.

Resident #30 was observed on August 28, and 29, 2014, and September 2, 2014, with facial stubble. An electric razor for the resident was plugged in the bathroom and in working order. The plan of care indicated that they required total assistance by staff with bathing and personal hygiene due to cognitive impairment. Interview with PSW staff on September 2, 2014, at 1300 hours, confirmed that the resident was not shaved with morning care. [s. 32.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

Resident #30 had upper and lower dentures. The resident reported that oral care was not provided twice a day, that their dentures were removed and cleaned at bedtime, and returned in the morning, however; staff did not clean the resident's mouth. Interview with PSW staff confirmed denture care was routinely completed however identified that they did not clean the resident's mouth with mouthwash, swabs or other methods. (168) [s. 34. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

Resident #30 reported an item which contained money, some time ago, to the inspector on August 25, 2014. A similar report was made to the staff by the resident on November 6, 2013, as identified in the progress notes. The note indicated that the staff were unaware of the presence of the item and suggested that due to a diagnosis the resident might have been confused. There was no indication in the complaints folder provided by the home for 2013, of the complaint, that action was taken to investigate, nor in follow up to the concern as expressed by the resident. [s. 101. (1) 1.]

Issued on this 5th day of September, 2014

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