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
Jun 29, 2016	2016_494165_0002	014419-16	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the City of Guelph
c/o The Elliott Long Term Care Residence 170 Metcalfe Street GUELPH ON N1E 4Y3

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

THE ELLIOTT COMMUNITY
170 METCALFE STREET GUELPH ON N1E 4Y3

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

TAMMY SZYMANOWSKI (165), LALEH NEWELL (147), LYNE DUCHESNE (117), MONIKA GRAY (594), SUSAN SQUIRES (109)

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): May 16, 17, 18, 19, 20, 24, 25 and 26, 2016

The following inspections were conducted concurrently during this inspection:
Log #022086-15 a complaint regarding staff to resident abuse;
Log #031624-15 a complaint regarding sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Director of Dietary Services, Dietary Aide, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident Assessment Instrument (RAI) Co-ordinator, Nurse Educator, Restorative Care Aide, Housekeeping staff, Financial Services Assistant, Human Resources Manager, IT Manager, Director of Recreation, Resident Council representative, Family Council representative, residents and families.

The inspector(s) also toured the home, observed meal service, medication administration, medication storage areas, reviewed relevant clinical records, reviewed policies and procedures, meeting minutes, schedules, posting of required information, observed the provision of resident care, resident-staff interactions and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **7 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 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with a range of continence care products based on their individual assessed needs.

Resident #005 was identified as having incontinence through the Resident Assessment Instrument-Minimum Data Set (RAI-MDS). Inspector #594 reviewed the resident's Continence Care Assessment completed on Admission and 90 days post admission which indicated that the resident used a pull up incontinent product for containment.

The resident's care plan indicated that the resident wears pull ups supplied by the home. In an interview with the inspector, Personal Support Worker (PSW) # 116 and # 135 said that the family provides the resident with pull ups. PSW # 134 reviewed the resident's care plan and said that the care plan was incorrect in identifying that the home provides the resident with pull ups, as the family did.

In an interview with the Substitute Decision Maker (SDM) of resident #005, they said to the inspector that when the resident was admitted to the home, they were notified that the home did not provide pull ups however, had the option to purchase the product through the home's supplier. Resident #005's SDM said to the inspector that they were able to purchase the pull ups at a lower cost elsewhere and have been supplying the resident with this product since admission.

In an interview with Registered Nurse (RN) # 104, it was said to the inspector that continence products available for residents were day light pads with mesh pants, large liner for more incontinence and all different briefs as indicated on the Tena Incontinence Management Form. A pull up could be made available but most families purchase these

for the resident.

The inspector reviewed an Incontinence Product Charges (Pull Ups) report provided by Financial Services Assistant #142 that indicated 17 residents were being charged for pull ups.

Review of the Continence Care and Bowel Management Program Policy #004 dated January 2010, indicated that registered staff were to ensure that residents were provided with a range of continence care products that were based on their individual assessed needs.

Review of the Accommodation Agreement indicated that supplies and equipment for personal hygiene and grooming including standard incontinence products (special order incontinence products requested by the Resident will be charged extra) were included with accommodation.

The inspector observed the home's incontinence supply inventory which included pads, liners and briefs.
In an interview with Director Of Care (DOC) #105, it was said to the inspector that Resident #005's family requested the resident use a pull up and they would purchase these for the resident, that the continence assessment indicated pull up because this was what the family requested for the resident. During the same interview the DOC said that the home did not carry a supply of pull ups as part of their regular product inventory

The licensee failed to ensure that resident's requiring pull ups were provided with a range of continence care products that were based on their individual assessed needs. [s. 51. (2) (h) (i)]

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 residents are provided with a range of continence care products that are based on their individual assessed needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers had been identified for the resident demonstrating responsive behaviours and strategies were developed and implemented to respond to these behaviours.
Resident #005 was identified as having increased behaviours through the Resident Assessment Instrument–Minimum Data Set (RAI-MDS) significant change assessment.

Inspector #594 reviewed the Resident Assessment Protocol (RAP) Summary triggered by responsive behaviours which documented that the RAP would be care planned. Review of the resident care plan by the inspector, failed to document responsive behaviours.

In an interview with Inspector #594, PSW #116 said that the resident would exhibit behaviours in the morning. PSW #135 said that the resident may refuse care and would yell at staff. PSW #134 and RN #137 said the resident would refuse to wear a specific device and RN #137 also said that the resident would wander and was at high risk for falls.

In an interview with the DOC #105, it was said to the Inspector that the resident did exhibit responsive behaviours. During the same interview, the DOC said that the care plan should have been updated to identify the behaviour triggers and have strategies developed, but did not.

Review of the Responsive Behaviours Policy #009 dated June 2003, documented that responsive behaviours that were repetitive but did not cause imminent danger to self or others had written strategies, including techniques and interventions to prevent or minimize responsive behaviours would be integrated into the plan of care. [s. 53. (4) (a)]

2. The licensee has failed to ensure that behavioural triggers had been identified for the resident demonstrating responsive behaviours and strategies were developed and implemented to respond to these behaviours.

A RAI-MDS assessment dated in 2015, indicated resident #009's behavior had deteriorated over the past 90 days. The assessment identified that the resident exhibited specific behaviours at least one to three times per week. The most recent RAI-MDS assessment indicated resident #009's behaviour had deteriorated and the Resident Assessment Protocol (RAP) indicated that the resident experienced specific behaviours at least one to three days per week during the observation period. The resident also experienced a specific behaviour at least four to six days per week during the observation period. These behaviours were not easily altered by staff and the assessment indicated that the behaviours would be addressed in the care plan.

A review of PSW documentation related to behaviours identified that the resident exhibited resistive behaviour five out of eight days during an eight day period in 2016.

During an interview with PSW #113, #117 and RPN #100, resident #009's behaviour was described to include specific behaviours.

Review of resident #009's current plan of care, it did not identify the specific behaviour, the triggers and developed strategies for the resident.

On May 24, 2016, DOC #105 acknowledged that the resident's plan of care did not include the behavioural triggers and strategies to manage the resident's behaviour related to resisting care. DOC #105 stated that the plan of care did not provide direction to staff and should have included included the behavioural triggers and strategies to manage resident #009's behaviours. [s. 53. (4) (b)]

3. The licensee has failed to ensure that behavioural triggers had been identified for the resident demonstrating responsive behaviours and strategies were developed and implemented to respond to these behaviours.

A RAI-MDS assessment dated in 2015, indicated resident #007's behaviour had deteriorated over the past 90 days. The assessment identified that the resident exhibited a specific behaviour six out of the seven days during the observation period. The assessment identified that this was a new RAP for the resident and that the behaviour would be care planned with the goal of improvement.

The most recent RAI-MDS assessment indicated resident #007 exhibited a specific behaviour one to three days during the observation period. The assessment identified that the care plan would be continued with the goals of monitoring resident for increased signs and symptoms of cognitive decline and increased behaviours.

During an interview with PSW #102 and RPN #100, it was stated that resident #007's behaviour was only exhibited around a specific time.

Review of resident #007's current plan of care, it did not identify the resident's specific behaviour, the triggers and the development of strategies for the resident.

On May 19, 2016, DOC #105 acknowledged that the resident's specific behaviour was not identified in the plan of care, did not include the behavioural triggers and strategies to manage the behaviour however, should have. [s. 53. (4) (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 behavioural triggers have been identified for the resident demonstrating responsive behaviours and strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. 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.

The nutritional status RAP of resident #009 completed by Registered Dietitian #121, indicated that resident #009 refused meals and going to the dining room. The assessment identified that the resident was underweight for their age and height and also indicated that tray service was offered when the resident chose not to go to the dining room.

On an identified day resident #009 was observed in their bed and made a request to the inspector for staff assistance to get out of bed. PSW #102 reported that the resident chose not to get up to go to the dining room for a meal and remained in bed when PSW #102 initially entered the resident's room earlier.
An identified period of time later resident #009 stated to the inspector that they did not have their meal yet and was getting hungry.
PSW #122 entered the resident's room 20 minutes later to offer the resident a drink off the nourishment cart. PSW #122 assisted the resident however, did not continue to offer nourishment once the resident was settled.

Interview with PSW #102, #122 and #123 reported that resident #009 did not receive a tray. The resident was provided a snack after the inspector inquired.

During interviews with PSW #102, #113, #117, DOC #105, Director of Food Services #124 and Registered Dietitian #121, it was reported that trays would be saved and offered to residents after meal service subsided and the resident was awake.

DOC #105 acknowledged that resident #009 should have been offered a tray when staff assisted the resident in getting up from bed initially.
The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

WN #4: 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 any policy instituted was complied with.

Review of the Continence Care and Bowel Management Program Policy #004 dated January 2010, indicated that registered staff were to conduct a bladder continence assessment after any change in status that may affect bladder continence.

Resident #005 was identified as having incontinence through the RAI-MDS Significant Change in Status Assessment. Inspector #594 reviewed the resident's Continence Care Assessments completed on Admission and 90 days post admission which indicated that the resident used a pull up incontinent product for containment.

In an interview with the inspector, RN# 137 said that the resident wore a brief because of a a recent change but would have to review the Resident Profile Worksheet.

The inspector reviewed the Resident Profile Worksheet with RN #137 which indicated that resident #005 required a brief. RN #137 said that DOC #105 would have the most updated list which was reviewed by the inspector and indicated that the resident wore a pull up.

In an interview with DOC #105, it was said to the inspector that a continence assessment was required to be completed when there was a significant change in the residents health and that resident #005 should have had a continence assessment completed and did not. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails.

A review of bathing records indicated that nail care had been completed for resident #009 two days prior to the first observation.

On two separate occasions during the inspection at specified times, resident #009 was observed to have untrimmed dirty fingernails with dark black debris under the nails. On another occasion, resident #009's fingernails were observed to be clean however, remained untrimmed.

Director of Care #105 acknowledged that the resident's fingernails should not have been left for the observed five days with no fingernail care provided when the resident's nails were dirty and untrimmed. DOC #105 stated that the expectation would be that staff attempt to complete fingernail care when needed and not wait until the residents next bath day to complete.

The licensee failed to ensure that resident #009 received fingernail care, including the cutting of fingernails when their fingernails were unclean and untrimmed. [s. 35. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Resident #012 stated that their desired bedtime was not always supported. The resident said that sometimes staff come to assist the resident for bed however, the resident still wanted to stay up longer. The resident reported that their bedtime was based more on the staffs routine and stated that their bedtime should be their own choice.

During an interview, PSW #143 and #144 stated that the resident's bedtime depended on the day as the resident would want to stay up at times when they would initially go to assist the resident for bed. When asked what happened on the days the resident wanted to stay up longer, PSW #144 reported that they tell the resident that they need to assist with getting the resident to bed now in order to get their documentation completed prior to the end of their shift at 2200 hours. PSW #143 and #144 stated that if the resident was not assisted for bedtime prior to the end of their shift, that the staff members arriving for the next shift would not be happy.

DOC #105 acknowledged that the resident's desired bedtime should be supported. The licensee failed to ensure that resident #012 had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. [s. 41.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff member has been trained by a member of the registered nursing staff in the administration of topical medications, and the registered staff member who is permitting the administration is satisfied that the staff member can safely administer the topical medication.

On May 19, 2016, inspector #109 observed a medication pass for resident #012 which included administration of topical medications. According to RPN #100, the PSW staff administer the topical medications. RPN #100 stated that she did not know if PSWs were proficient at administering the topical medications safely as she had not observed staff member #102 administer topical medications.

During an interview with PSW #102, she reported that she has not been trained by the licensee in the proper administration of the topical medications.

During an Interview with PSW #103, she reported that she had been trained but was not aware of what the name of the medication was that she applied to the resident.
During an interview with Nurse Educator #110, she stated that she was providing education to all of the PSWs and currently 16 out of 64 (25%) of the PSW's had been trained to safely administer topical medications.

During an interview with DOC #105, she reported that the home was aware that this was a deficit and were in the process of educating their PSW staff to ensure topical medications were safely administered to the residents [s. 131. (4)]

Issued on this 29th day of June, 2016

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

Original report signed by the inspector.